ATRIA
Medical Institute

TRANSCRIPT RELEASE FORM

Authorization to Release Records: I hereby request Atria Medical Institute to release my records, to include current and previous grades, GPA and other information. I accept all legal responsibility and by my signature below release Atria Medical Institute and their agents from any liability, regardless of the action, which might result from the release of the information I have requested.

STUDENT INFORMATION

Name used when student attended AMI: (write legibly)

_____ _____ _____

First Name **Middle Name** **Last Name**

Date of Birth: _____ **Social Security #:** _____ - _____ - _____

Current Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

Cell Phone: _____ **Other Phone:** _____

Year of attendance: _____

RECIPIENT INFORMATION: (write legibly) AMI is not liable for misdirected mail; be sure of the recipient's address

Send transcript to: _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Requested information is to be: _____ **mailed** _____ **picked up** _____ **faxed** _____ **emailed**

If transcript is to be emailed, please provide email address: _____

If transcript to be faxed, please provide fax number: _____

AMI will not be responsible for student information that is received by an entity other than the intended recipient when fax number or email address provided is incorrect.

PERSON AUTHORIZED TO PICK UP RECORDS: (write legibly)

NAME: _____

Relationship: _____

Please allow up to 3 days for processing. Requested information will not be issued to a student whose record indicates financial indebtedness to the institution.

Signature: _____ **Date:** _____

Registrar Initials: _____ **Date Completed:** _____