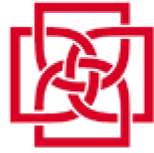

REQUEST TO RELEASE ACADEMIC RECORDS

Date: ______________

Name: ____________________________________

Social Security #: ____________________________

Address: ___________________________
____
____

I, _____________________________ have requested the release of my Academic Records. By completing this form I give DeKalb Medical Center School of Radiologic Technology authorization to release my Academic Records to the following:

____ Myself

____ School/ College/ Organization (please ***print*** the address of the place it is to be sent below)

(Name of School/Organization) _______________________________
(Address) _______________________________
____

Number of copies requested: _____ ($5.00 per transcript)

X _________________________________
(Please Print Name Here)

X__________________________________
(Please Sign Name Here)

Date: _______________________________

Please mail completed request to the following address:

DeKalb Medical School of Radiologic Technology
c/o R.T. School Director
2701 N. Decatur Road
Decatur, GA 30033