

REQUEST TO RELEASE ACADEMIC RECORDS

Date: _____

Name: _____

Social Security #: _____

Year of Graduation: _____

Request for Transcripts (**\$5.00 per Transcript**) # of Copies Requested: _____

Request for Certificate (**\$25.00 per Certificate**) # of Copies Requested: _____

Address: _____

I, _____ have requested the release of my Academic Records. By completing this form I give Emory Decatur Hospital School of Radiologic Technology authorization to release my Academic Records to the following:

Myself

Name of School/Organization: _____
Address: _____

X _____
(Please Print Name Here)

X _____
(Please Sign Name Here)

Date: _____

Please remit all correspondence to:

*Emory Decatur Hospital School of Radiology
c/o R.T. School Director
2701 North Decatur Road
Decatur, GA 30033*