Reading Hospital School of Health Sciences
Request for Release of Records

Print name (RHSHS student/graduate): _____

Permission is granted to release records to (PRINT CLEARLY):

Name	Pennsylvania Sigma Chapter - Lambda Nu
Address	SHS - 1025 Old Wyomissing Rd Reading PA 19612
Fax	
Email	

Permission is granted to release the stated records for the purpose of: Membership

_____

Name During Enrollment in the school (printed/legible)_____

Student ID number or social security number _____

Year(s) of attendance: _____ (Example: 1997-1999)

Enrolled Program(s) (Check all that apply)

☐ Nursing Program

☐ Clinical Pastoral Education Program

☐ EMS Program (EMR, EMT, AEMT, Paramedic, PHRN)

☒ Medical Imaging/Radiologic Technology Program

☐ Surgical Technology Program

I hereby give permission for the Reading Hospital School of Health Sciences to release the following records (check all that apply)

☐ Official Transcript ($10.00)

☒ Grades (Unofficial transcript)

☐ **Clinical and academic evaluations

☐ **Other _____

** Note: Permission of Program Director or designee required for release of these records. Initial_____
Financial records are released via a separate request form from the Director of Financial Aid

Signature of RHSHS student/graduate_____ Date _____