REGISTRAR OFFICE

REQUEST FOR RELEASE OF RECORDS

STUDENT INFORMATION

Student Name:
Student Name During Enrollment:
Student ID Number or Social Security Number:
Year(s) of Attendance:
Release of Records Purpose:

ENROLLED PROGRAM(S) ***(Check all that apply)***

Nursing	Medical Imaging/Radiologic Technology	
Surgical Technology	Medical Laboratory Science	Phlebotomy
Diagnostic Medical Sonography	Emergency Medical Services (EMT, AEMT, Paramedic, PHRN)	

PERMISSION IS GRANTED TO RELEASE TRANSCRIPTS TO:

Name:		Email:	
Address1:			Fax:
Address2:	City:	State:	Zip:

PLEASE SELECT RECORDS TO BE RELEASED. ***(Check all that apply)***

Official transcript ($10.00)	Grades (Unofficial Transcript)	**Clinical & Academic Evaluations
**Other (please explain):		

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

I hereby give permission for Reading Hospital School of Health Sciences to release the following records to the above-named individual.

Student/Graduate Signature:____ Date: ______________

Return Form To:	Reading Hospital School of Health Sciences Registrar's Office PO Box 16052 Reading, PA 19612-6052	Or Fax to: 484-628-0134 Questions: 484-628-0142