



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)

<input type="checkbox"/> Nursing	<input type="checkbox"/> Medical Imaging/Radiologic Technology	
<input type="checkbox"/> Surgical Technology	<input type="checkbox"/> Medical Laboratory Science	<input type="checkbox"/> Phlebotomy
<input type="checkbox"/> Diagnostic Medical Sonography	<input type="checkbox"/> 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)

<input type="checkbox"/> Official transcript (\$10.00)	<input type="checkbox"/> Grades (Unofficial Transcript)	<input type="checkbox"/> **Clinical & Academic Evaluations
<input type="checkbox"/> **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: 484-628-0115
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