

PERMISSION FOR RELEASE OF INFORMATION

Name: _____ Date: _____
Last *First*

Date of Birth: _____ Student ID/SSN: _____

Are you currently enrolled? Yes No Program Enrolled: _____

Campus (Circle one): ATI ACADEMIC Are you a SACM student? Yes No

Contact Number: _____ Contact Email: _____

TYPE OF REQUEST:

Letter of Verification (Circle semesters) Fall Spring Summer (YYYY) _____

➤ Specify reason (if custom letter is needed): _____

Immunization Record

Academic Completion Letter (Pending Graduation status) *

Other (please specify): _____

Attention

- Normal processing time is 24-48 business hours. Processing times may be longer during peak registration periods.
- *All financial & other obligations to the College must be fulfilled.

INFORMATION TO BE RELEASED TO:

NAME: _____

ADDRESS: _____

ATTN TO: _____

EMAIL ADDRESS/FAX NUMBER: _____

Please choose Method:

- I want my request to be mailed to the above address
 I prefer to pick up my request on given date.
 I want my request to be fax/e-mailed

Student Signature:

Office Use Only

Program Code: _____

Processed By: _____

Date: _____

*For pick up only**

Student initials: _____

Date: _____