



AUTHORIZATION to RELEASE INFORMATION

I, _____ SSN: _____

hereby request the release of the following information from my medical school records:

Quantity

_____ Letter of Academic Standing
Describe reason letter requested: _____

_____ Dean's Letter / Medical Student Performance Evaluation (MSPE)

_____ Transcript – There is a \$5.00 fee per transcript. (No charge for enrolled students.)

_____ **Official** – (issued in a sealed envelope)

_____ **Unofficial** – (marked issued to student)

_____ Certified Photocopy of Diploma
(Please note: Graduates prior to 1997 must provide the diploma photocopy for certification.)

_____ Other, please describe: _____

_____ Replacement of Original Diploma – There is a \$15.00 fee per diploma. (Allow 2-3 weeks for printing)
Please indicate **exactly** how name should appear on diploma and date of graduation:

I authorize the release of the above information to me and I will pick it up in the Student Affairs Office.

or

I authorize the release of the above information to me at the address indicated below:

or

I authorize the release of the above information to the company or institution at the address indicated below:

Attention: _____

Company /Institution: _____

Address: _____

City, State, Zip Code: _____

Authorization Information:

Signature: _____ Date: _____

Address: _____ Phone: _____

Payment Information:

Cash Check Money Order Credit Card Payment: Visa MasterCard

Account # : _____ Exp. Date: _____ Amount to be charged: \$ _____

Name as it Appears on Card: _____ Signature: _____

Return Completed form to: Jennifer Langley, Registrar
SIU-SOM, Student Affairs
P.O. Box 19624
Springfield, IL 62794-9624
Phone: (217)545-0890 Fax: (217)545-5538