



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, Office of Student Affairs
P.O. Box 19624
Springfield, IL 62794-9624
Phone: 217-545-0890 Fax: 217-545-5538