# Transcript Request and Authorization for Release of Records

- o Unofficial Transcript (for student personal use)
- o Official Transcript (sent to schools and agencies only)
- o Records review
- o Health Record

Name

Former name used at school

Leaving year

eMail

I authorize and request the School of Nursing to furnish copies of my record(s) as indicated. I understand and agree that this information will not be given, sold, transferred or in any way relayed to any other person unless specified on this consent form. I release St. Joseph Health Services of Rhode Island and the School of Nursing from all legal responsibility or liability that may arise from this authorization.

Signature Date

Student / Graduate Address

Phone

Send document(s) to

Fee collected

Signature

Date

Financial obligations cleared

Signature

Date

Documents transmitted

Signature

Date

Other Remarks