



Authorization to Release Information

I, _____

Class of: _____

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: _____ 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: _____
 Email: _____
 City, State, Zip Code: _____

Authorization Information:

Signature: _____ Date: _____
 Address/Email: _____ Phone: _____

Payment Information:

Cash Check Money order Credit Card Payment: Visa MasterCard

Account Number: _____ Expiration Date: _____ CVV: _____ Billing Zip-code: _____

Amount to be charged: \$ _____ Name as it Appears on Card: _____ Signature: _____

PLEASE RETURN COMPLETED FORM VIA: MAIL, FAX, OR EMAIL TO:

TERRA COLLINS, REGISTRAR
 Phone: 217.545.2860 | Fax: 217.545.5538

registrar@siumed.edu

SIU School of Medicine
 Office of Student Affairs, RM 3080
 801 N. Rutledge St.
 Springfield, Illinois, 62794