SIU SCHOOL of MEDICINE

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

Revised 9/09/21