



DeKalb Medical

REQUEST TO RELEASE ACADEMIC RECORDS

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Year of Graduation: \_\_\_\_\_

# of Copies Requested: \_\_\_\_\_ (*\$2.00 per Transcript*)

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I, \_\_\_\_\_ have requested the release of my Academic Records. By completing this form I give DeKalb Medical School of Radiologic Technology authorization to release my Academic Records to the following:

\_\_\_ Myself

\_\_\_ Name of School/Organization: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_  
(Please Print Name Here)

X \_\_\_\_\_  
(Please Sign Name Here)

Date: \_\_\_\_\_

*Please remit all correspondence to:*

*DeKalb Medical School of Radiology  
c/o R.T. School Director  
2701 North Decatur Road  
Decatur, GA 30033*