

UPMC Shadyside

School of Nursing

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AUTHORIZATION FOR THE RELEASE OF ACADEMIC TRANSCRIPT

I hereby authorize UPMC Shadyside School of Nursing to release my academic transcript to the following parties:

Name: _____

Address: _____

Name: _____

Address: _____

Name used while student: _____

Present name: _____

Present address: _____

Year of graduation or attendance: _____

I release the faculty and/or administration from any and all liability which may arise in connection with the release of my UPMC Shadyside School of Nursing academic transcript.

The Family Educational Rights and Privacy Act of 1974 prohibits UPMC Shadyside School of Nursing from releasing academic transcripts (and other confidential information) without the student's written consent. Thus, requests via telephone or e-mail cannot be honored.

Signature Date

Name Printed