UPMC LIFE CHANGING MEDICINE

Authorization to Release Academic Transcript
Mercy Hospital School of Nursing

(PER THE TRANSCRIPT POLICY, OFFICIAL ACADEMIC TRANSCRIPTS WILL NOT BE ISSUED UNTIL ALL ACCOUNTS WITH ANY OF THE UPMC SCHOOLS OF NURSING HAVE BEEN PAID IN FULL)

Student Information:

Student Name: _____

(if different) Name During Attendance: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email Address: _____ **Phone:** _____

Social Security Number: _____ **Graduation Date:** _____

School Graduated From: ☐ **Mercy SON** ☐ **St. Francis SON** ☐ **St. Joseph's SON** ☐ **South Side SON**

I hereby authorize the Mercy Hospital School of Nursing to release my academic transcript to the following:

Name: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

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

The Family Educational Rights and Privacy Act of 1974 prohibits the Mercy Hospital 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.

The cost of an academic transcript is $5.00 and must be submitted with the request. Please send payment in the form of check or money order and this form to the address listed below.

Please make check or money order payable to: *Mercy Hospital School of Nursing*

Mercy Hospital School of Nursing
Attn: Registrar
1401 Boulevard of Allies
Pittsburgh, PA 15219

_____

Signature *Date*

Approved: Policy Review Committee 3/3/06; 9/3/10
Approved: Faculty Organization 3/20/07; 9/20/10; 2/20/12; 11/7/12
Approved: UPMC Schools of Nursing 7/11/13; 8/27/18
Effective Date: 2/20/12; 11/7/12; 7/11/13; 8/27/18
VERSION 4