ANGIO
Medical Assisting Institute

TRANSCRIPT RELEASE FORM

Authorization to Release Records: I hereby request Angio Medical Assisting Institute to release my records, to include current and previous grades, GPA and other information. I accept all legal responsibility and by my signature below release Angio Medical Assisting Institute and their agents from any liability, regardless of the action, which might result from the release of the information I have requested.

STUDENT INFORMATION (NAME USED WHEN STUDENT ATTENDED AMAI)

_____ _____ _____

First Name Middle Name Last Name

Date of Birth: _____ Social Security #: _____

Current Mailing Address: _____

City: _____ State: _____ Zip: _____

Cell Phone: _____ Other Phone: _____

RECIPIENT INFORMATION *AMAI is not liable for misdirected mail; be sure of the recipient's address

Send transcript to: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Requested Information is to be: _____ mailed _____ picked up _____ faxed _____ emailed

If transcript is to be emailed, please provide email address: _____

If transcript is to be faxed, please provide fax number: _____

*AMAI will not be responsible for student information that is received by an entity other than the intended recipient when fax number or email address provided is incorrect.

Person Authorized to Pick Up Records:

Name: _____

Relationship: _____

Please allow up to 3 days for processing. Requested information will not be issued to a student whose record indicates financial indebtedness to the institution.