



## School of Medical Laboratory Science

I hereby authorize the UF Health Jacksonville School of Medical Laboratory Science to release official copies of my academic record to the person or institution named below with the understanding that the named recipient will not release the record to a third party without my written consent.

Your name: \_\_\_\_\_

Your name while attending the program, if different: \_\_\_\_\_

Year you attended the program: \_\_\_\_\_

Last four digits of your Social Security Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

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

City, State, ZIP Code: \_\_\_\_\_

Send academic record to:

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

City, State, Zip Code: \_\_\_\_\_

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

Signature: \_\_\_\_\_

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