SAINT JAMES
SCHOOL OF MEDICINE
Your Future. Our Promise.

STUDENT RECORD RELEASE FORM

Saint James School of Medicine must have a signed acknowledgment from you before educational/financial information can be released to a third party (i.e., parent, spouse, etc).

Please complete all items below and return this authorization form to info@mail.sjsm.org

STUDENT INFORMATION

Student's Name (Last, First, Middle Initial) Student ID

Campus Daytime Phone Number Alternate Phone Number

Street Address

City, State Zip

AUTHORIZED INDIVIDUAL

Check one: ☐ Release Information to ☐ STOP Releasing Information to

Release: ☐ ONLY Academic Records ☐ ONLY Financial Records ☐ ALL Records
☐ OTHER _____

Name (Last, First Middle Initial)

Daytime Phone Number Alternate Phone Number

Street Address

City, State Zip

RELEASE AUTHORIZATION

I hereby authorize Saint James School of Medicine to release information regarding my academic/financial records to the individual named above in person or over the phone. Please note that the third party must know your student ID number when calling the school.

Student Signature Date