THOMAS UNIVERSITY
Office of the Registrar
Thomasville, GA 31792
(229) 226-1621

STUDENT RECORDS RELEASE FORM

STUDENT AUTHORIZATION FOR RELEASE OF RECORDS

STUDENT NAME:_____
Last First MI

STUDENT I.D. (SSN):_____

I hereby authorize Thomas University to release information contained in my student records to the party listed below upon receipt of written request, or upon the determination of appropriate University officials. ***I understand that this authorization will remain in effect until I submit the necessary changes, in writing, to the Registrar's Office.***

_____ _____
Student Signature (required) Date

RELEASE TO:

Name:_____

Address:_____
Street

_____
City State Zip Code

Contact Number(s):_____

INFORMATION TO BE RELEASED: