Cabarrus College of Health Sciences
Transcript and Educational Records Request Form

In compliance with the Family Educational and Privacy Act (FERPA) of 1974 as amended, Cabarrus College of Health Sciences will not release student information beyond the college's directory information (with exceptions as outlined in § 99.31) to any third party without written permission by the student.

Full Name	**Maiden Name**	**Last Four of SSN**	**Date of Birth**
Street Address			
City	**State**	**Zip**	
Email	**Phone Number**		

Record Requested	☐ Transcript	☐ Medical Records	☐ References	☐ Other:_____
Number of copies				
Send Copy Via	☐ Mail	☐ Fax		
School/Business/Person				
Street Address				
City	**State**	**Zip**		
Fax Number				

I give the Cabarrus College of Health Sciences permission to release my records to the college, business, or individual outlined above.

_____
Student Signature ***Date***

Administrative Use Only.
Amount Paid: _____ Date: _____ Ch #: _____

Cash: _____ CC: _____ Payment Processed By: _____

Request Completed by: _____ Date: _____

There is a $5.00 fee per record requested. Payment can be made with cash, check or money order (made payable to Cabarrus College of Health Sciences) or with credit card. To pay via credit card, please complete the information below:

Amount to be charged ($5.00 per transcript): _____ Credit Card Type: ☐ Visa ☐ Master Card ☐ AMEX Credit Card Number: _____

Name on the Card: _____ Expiration Date: _____ V-Code from the back: _____ Billing Zip Code: _____

Credit Card Payment Authorization Signature: _____

Revised 6/12/18