ACADEMIA MEDICAL INSTITUTE

Please fax back:
Academia Medical Institute
Student Service Department
Send payments to
3445 South Blvd
Columbus, Ohio 43204
614-674-6682

Student Transcript Request Form

The family Education Right and Privacy Act of 1974 (as amended) prohibits the release of this information without the student's written consent. Failure to complete this form in its entirety may delay processing of your request. Request will be processed within 7-10 Business days.

Name: _____

Previous name(s): _____

Address: _____
Date of Birth: _____ Telephone: _____

Please send transcript request(s) to the following address or we can email/fax:
_____
_____

I hereby authorize an official copy of my records to be released by Academia Medical Institute to the third party listed above. I understand that Academia Medical Institute will not release records until all financial obligations are met.

_____ _____
Student Signature Date

$25 Transcript processing fee applies for all Transcript Requests		
☐ **VISA**	☐ **MasterCard**	☐ **Discover**
Card Number _____	**Card Number** _____	**Card Number** _____
Expiration Date _____	**Expiration Date** _____	**Expiration Date** _____
Exact Name: _____	**Exact Name:** _____	**Exact Name:** _____