



Request to Release Education Records

Name: _____ Student ID _____

Date of Birth: _____ Last four digits of SSN: _____

Phone: _____ Email _____

I do hereby give my permission to Eastern Shore Community College

to release the information listed below to:

email address:

Company/Organization

Address

City

State

Zip Code

Item(s) of information to be released:

Student Signature: _____ Date: _____

Return Completed Form to: registrar@es.vccs.edu