Request to Release Education Records

Name: _____ Student ID_____

Date of Birth: _____Last four digits of SSN: _____Graduation Year: _____

Phone:_____Email_____

I do hereby give my permission to Eastern Shore Community College to release my educational records to the following people/organization:

_____

email: ☐ Mail: ☐ Print: ☐

School: _____ email address: _____

School: _____ email address: _____

School: _____ email address: _____

School: _____ email address: _____

School: _____ email address: _____

_____

Company/Organization email address

_____

Address

_____

City State Zip Code

Item(s) of information to be released: Official Transcript: ☐ Verification Letter: ☐ Other: ☐

_____

_____

Student Signature: _____Date: _____

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

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