

THIRD PARTY AUTHORIZATION
2020-2021

(Student's Full Name)

I hereby authorize, **Capital Area School of Practical Nursing, 2201 Toronto Road, Springfield, IL 62712**, to release information as indicated below, to the following organization/ individual

(3rd Party Designee)

Documents/Records authorized for release (mark each item to be included):

- | | |
|---|--|
| <input type="checkbox"/> Acceptance Letter | <input type="checkbox"/> Financial Aid Offer (Award) Letter |
| <input type="checkbox"/> Class Schedule | <input type="checkbox"/> Student Account billing information |
| <input type="checkbox"/> Attendance Records | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Academic Transcript(s) | <input type="checkbox"/> Other: _____ |

Please note that your authorization to release information has no expiration date; however, you may revoke your authorization at any time by sending a written request to the same address.

Third Party Designee Information

3rd Party Designee's Full Name (organization or individual)

Current Address (Street/PO Box, Apt,)

(City, State & Zip)

Daytime Phone

Student Information

Student Full Name

Current Address (Street/PO Box, Apt)

(City, State & Zip)

Daytime Phone

Student Signature

Date