THIRD PARTY AUTHORIZATION
2018-2019

____
(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):

- ☐ Acceptance Letter
- ☐ Class Schedule
- ☐ Attendance Records
- ☐ Academic Transcript(s)
- ☐ Financial Aid Award Letter
- ☐ Student Account billing information
- ☐ Other: ________________________________
- ☐ 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