DMC
Sinai-Grace
Hospital

# RELEASE OF RECORDS

I, _____
hearby authorize the Sinai-Grace Hospital School of Radiologic Technology to release my records to the following:

Transcripts: Year of Graduation _____

Other:
_____

Release to:

_____

Address:

_____

City/State/Zip Code:

_____

Your Current Name:

_____

Former Name (if applicable):

_____

Current Address:

_____

City/State:

_____

Zip Code:

_____

Phone Number (with area code):

_____

_____ _____

Signature Date

***Please include a check or money order made out to Sinai Grace Hospital in the amount of $3.00 and return to:***

***Sinai Grace Hospital***
***School of Radiologic Technology***
***6071 West Outer Drive***
***Detroit, MI 48235***