

THE SOMA INSTITUTE

THE NATIONAL SCHOOL OF CLINICAL MASSAGE THERAPY

Student Authorization for Release of Information—Student Records

Please allow 10 business days to process your request.

I, _____, by my signature below, do
(Print Name)

hereby authorize The Soma Institute to release information regarding the following:

- attendance records, including enrollment verification
- course grades and transcripts
- financial records, including financial aid
- disciplinary records
- admissions records
- other (Please specify): _____

upon request of the individual/company designated below: (“To Whom It May Concern” cannot be issued.)

Name

Company Name (if applicable)

Address

Telephone Number

Fax Number

Signature

Date

For Office Use Only

Received On: _____ Initials: _____

Request Approved _____ Initials: _____

Information Released On (Date) _____ Initials: _____

Request Denied _____

Reason _____