



Authorization to Release Educational Records

Student Name: \_\_\_\_\_

Last Four Digits of SS#: \_\_\_\_\_

Birth Date (MM/DD/YY): \_\_\_\_\_

---

**Specify the records to be sent:**

- Undergraduate and Graduate Transcripts
- Letters of Professional Recommendation
- Resume
- MCAT scores

**To whom do you want them released:**

Davenport University  
Attn: Online Department  
415 East Fulton St  
Grand Rapids, MI 49503  
Phone: 800-203-5323  
Fax: 800-811-2658  
Email: amy.ostrow@davenport.edu

**What is the purpose for the release:**

- Application to Graduate School

---

Student Signature

---

Date