



Transcript Release Authorization

Name of School: _____

Student's Name at
Time of Attendance: _____

Date of Birth: _____ Date of Graduation: _____

Number of Transcripts Requested: _____ (Fee of \$5 per transcript)

Requestor's Contact Information

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____ Email: _____

Transcript Mailing Address (if different from above)

Name: _____

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Authorization

Signature

Date

Mail Request to:

Archives of the Archdiocese of New York
201 Seminary Avenue
Yonkers, NY 10704

A signed, paper copy of this form must be mailed in to the address at left. A copy of a state-issued photo ID **MUST** accompany this form. There is a non-refundable fee of \$5.00 per request. Cash, cashier's checks, and money orders are acceptable forms of payment, payable to the Archdiocese of New York. Personal checks are not accepted.

For Office Use Only

Date Transcript Mailed:	By:	Fee Paid: