



### 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: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

### Authorization

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

#### Mail Request to:

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

A copy of a state-issued photo ID **MUST** accompany this form. There is a non-refundable fee of \$5.00 per transcript 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

<b>Date Transcript Mailed:</b>	<b>By:</b>	<b>Fee Paid:</b>