Authorization for Disclosure of Personal Information
Education Verification and Transcript Request

Student Information:

Surname:	
Given Name:	
Maiden/another name (if applicable):	
Date of Birth (dd/mm/yyyy):	
Campus Attended: (i.e. Kenmount Road, etc.)	
Specify Program and Years Attended:	
Mailing Address:	
Email Address:	

How do you wish to receive your transcript?

☐By Email to the email address noted above
☐By Email to the email address noted below
☐By Mail to the mailing address noted above
☐By Mail to the address below

Company/Institution Name:	
Contact Person's Name:	
Email Address:	
Mailing Address:	
Telephone Number:	

☐By Fax to

Fax #:	
Attention:	

☐In Person

Persons Name (they must have ID):	

Consent:

I (please print) _____, hereby authorize Academy Canada to release academic information to the name/institution and address provided above.

_____ _____
Signature Date