



## Official Transcript Release Authorization

1120 E. Kennedy Blvd.; Suite 214  
Tampa, FL 33602  
Phone 877-856-2144 \* Fax 888-743-8116  
[COLAdmission4@saintleo.edu](mailto:COLAdmission4@saintleo.edu)

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To:  
Office of Registrar: \_\_\_\_\_  
College/University Name \_\_\_\_\_

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College/University address and or location (include City & State) \_\_\_\_\_

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Dates of attendance (from / to) \_\_\_\_\_

I authorize release of my official transcript to:

**Saint Leo University  
ATTN: Admissions  
1120 E. Kennedy Blvd.; Suite 214  
Tampa, Florida 33602**

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Student Name \_\_\_\_\_ Student Date of Birth \_\_\_\_\_

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Name on transcript (if different from above) \_\_\_\_\_

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Address \_\_\_\_\_

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City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

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(\_\_\_\_\_) \_\_\_\_\_  
Phone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Attention Registrar's Office:

Please process this request within 2 weeks of receipt. If any difficulties are encountered within this request, please contact: [COLAdmission4@saintleo.edu](mailto:COLAdmission4@saintleo.edu)

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Student's Physical Signature \* \_\_\_\_\_ Date \_\_\_\_\_

\* Required for release of transcript under the Family Education Rights and Privacy Act of 1974.

**FOR OFFICE USE ONLY: MUST be complete before ordering the official transcript.**

**ID#:** \_\_\_\_\_ **Date requested:** \_\_\_\_\_ **Fee:** \_\_\_\_\_ **Payment Method:** \_\_\_\_\_

**LOC:** \_\_\_\_\_ **Photo ID:** \_\_\_\_\_ **S/R:** \_\_\_\_\_ **Fax #:** \_\_\_\_\_

Revised 03/06/17