



Office of the Registrar

1601 Maple Street
Carrollton, Georgia 30118-1600
Fax: 678-839-6439

Transcript Pickup Release Form

Date _____

Student Name: _____ ID#/ SSN# _____

Phone _____

(Student must submit a photo ID with this form.)

I hereby give _____ permission to receive my transcript in my absence.

I understand that a separate transcript order must be placed prior to its release.

*By signing this form, I accept full responsibility for the document(s) I have requested for release to the above named person. The information is intended for the use of myself or entity to whom I have requested the document(s) be sent, and contains information that is privileged and confidential, the disclosure of which is governed by applicable law.

Student's Signature _____ Date _____

Signature of Recipient _____ Date _____

*Recipient must sign the form when the transcripts are received.
*Recipient must provide a form of photo identification to receive the transcripts.

For Registrar's Office Purposes Only:

ID Checked [] Staff Signature _____ Date _____