New York City Campus:
Registrar
Nyack College
2 Washington St
New York, NY 10004
(646) 378-6192
servicecenter@nyack.edu

Permission for Release of Immunization Records

Complete this form and return it to the Registrar's Office or servicecenter@nyack.edu

Name:_____SS#:_____

Date of Birth: _____/_____/_____ Degree Program: _____ Campus: _____
MM DD YEAR

Address:_____ Apt/Suite: _____

City: _____State:_____ Zip Code: _____

I, _____ hereby request and consent to Nyack College / Alliance Theological Seminary releasing a copy of my immunization records to:

Name: _____

Address: _____

_____

_____

Fax Number: _____

College Transcript Name: _____

_____

Student Signature:_____ Date: _____