Print Form

UT SOUTHWESTERN
THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER
AT DALLAS

Office of the Registrar
5323 Harry Hines Boulevard
Dallas, Texas 75390-9096
(214) 648-3606
(214) 648-3289 Fax

REQUEST TO REVIEW EDUCATION RECORDS

Student ID #: 100- -

Student Date of Birth: / /

Classification
☐ Student
☐ Alumni

School
☐ Medical ☐ Health Professions (formerly Allied Health)
☐ Graduate ☐ Nurse Practitioner/Midwifery

Dates of Attendance: / / to / /

Name of Student (Last, First, Middle):

Purpose of Review:

Item(s) of Information Requested:

☐ Application
☐ Other

Method of Delivery:

◯ **PICK UP** from the Registrar's Office located in the Bryan M. Williams Student Center (*building MA 2.200*)

◯ **E-MAIL** to your UT Southwestern e-mail account (*applicable only to currently enrolled students*)

◯ **FAX to:** Attention:
Fax #: ( ) -

◯ **MAIL to:**
Address:
City: State: ZIP Code:

Name of Requestor:

Requestor's Affiliation: Phone #: ( ) -

I hereby agree to keep the information disclosed to me confidential according to applicable legislation and regulations.

Requestor's Signature *NOTE: REQUEST WILL NOT BE CONSIDERED WITHOUT A SIGNATURE.* Date

OFFICE USE ONLY Disposition of Request ☐ Approved ☐ Disapproved

Specify Materials Reviewed (Records, Types of Information)

Signature of Official Approving Request Date

Printed Name and Title of Official Supervising Review Date