BESt
PHARMACY SUMMER INSTITUTE

Student Authorization to Release Information or Request Letters of Recommendation

From: _____

Name of Student Student ID

_____

Student Address

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my educational records cannot be released without my written permission. Further, personally identifiable information from my educational records (grades, GPA, ACT/SAT scores) cannot be shared without my written permission.

I, therefore, authorize the release of (check all that apply):

- [X] Any transcript information
- [X] Graduation date
- [X] GPA and specific course information
- [X] ACT/SAT scores
- [X] College/University Acceptance/Enrollment
- [X] St. Louis Community College-Forest Park Student Number

To:

- [X] The Barnes-Jewish Hospital, Express Scripts, Inc, on the campus of St. Louis College of Pharmacy (BESt) Pharmacy Summer Institute

For the following purpose:

- [X] Admission to the BESt Pharmacy Summer Institute
- [X] Other (specify) BESt Pharmacy Summer Institute program reporting

I waive (☐), do not waive (☐), my right to see the recommendation or other information prepared pursuant to this release. This release shall be valid for a period of three (3) years following the date below or until revoked in writing.

_____

Signature of Student Date

_____

Signature of Parent/Legal Guardian Date