

Lutheran School of Nursing
request for copy of
Health Records

Name: _____

Please circle: **current student** **alumni** grad. class: _____

Date of birth: ____/____/____ last 4 digits of SSN: XXX-XX-_____

Please indicate specifically which records you are requesting copies:

Signature: _____

Please mail request form to the school, attn: Enrollment Coordinator
3547 S. Jefferson St. Louis, Mo 63118

There is a \$3 cash fee for copies due at time of request.
Allow 5 business days for the Enrollment Coordinator to complete your
request.

Current students: copies will be placed in your LSN mailbox.
Alumni: copies will be mailed at the address provided below:

Street: _____

City: _____ State: _____ zip: _____

Copies may NOT be released to a third party.

LSN reserves the right to deny release of records.
Records remain on file at LSN for a limited time after a student graduates.

Office use only:	
Date rec'd: _____	E.C. use only:
Rec'd by: _____	date to LSN box/mail: _____
\$3 fee pd.: <input type="checkbox"/> yes <input type="checkbox"/> no	completed by: _____ 6/15/10
Comments: _____	