AUTHORIZATION TO RELEASE INFORMATION TO
SCHOOL of PUBLIC HEALTH
ADMISSIONS & STUDENT AFFAIRS

FULL NAME _____

Social Security Number _____

By signing this form, I give permission to the Admissions and Student Affairs offices of the Louisiana State University School of Medicine in New Orleans to release the documents listed below in my LSUHSC School of Medicine records to the LSUHSC School of Public Health.

Information from these records will be used for the sole purpose of determining my eligibility for Admission to the Master of Public Health Degree Program.

The information to be released will consist of:

1. All undergraduate transcripts and LSUHSC transcripts

2. All Medical School and Graduate School transcripts

3. MCAT scores

4. Letters of Recommendations

5. Goal or Personal Statement

6. Resume or CV

Signature to permit release _____

Date signed: _____

Return this document to:

Isabel Billiot. M.Ed
Coordinator of Student Affairs
LSUHSC School of Public Health
2020 Gravier Street, 3rd Floor
New Orleans, LA 70121
504 568-5773
ibilli@lsuhsc.edu