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# FINANCIAL SERVICES

Quillen College of Medicine

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EAST TENNESSEE STATE UNIVERSITY

## Information Release Form

I, \_\_\_\_\_, give permission to the Office of Financial Services to release any information regarding my personal Financial Aid account, to the person(s) listed below. I also give said person(s) permission to handle any necessary business or paperwork on my behalf.

\_\_\_\_\_  
Person 1

\_\_\_\_\_  
Person 2

\_\_\_\_\_  
Person 3

\_\_\_\_\_  
Signature

\_\_\_\_\_  
E Number

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

P.O. Box 70580  
Johnson City, TN 37614-1708  
Phone: (423)439-2035 Fax: (423)439-2070