

**DIOCESE OF CORPUS CHRISTI**  
**Authorization to Release Student Transcript/Records from**  
**Closed Catholic Schools in the Diocese of Corpus Christi**

Please return this form signed and notarized with the research fee via **surface mail only** to: *Diocese of Corpus, Attn: Archives/Records, PO Box 2620, Corpus Christi, TX 78403*. Staff will process transcript requests only after receiving the above material.

**NOTE: A signature, along with a copy of a government issued photo ID, is required to process your request.** The requested records (if available) will be mailed within six (6) weeks after receipt of this completed form.

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**Authorization to Release Information**

I, \_\_\_\_\_, hereby authorize the Roman Catholic Diocese  
*(Name)*  
of Corpus Christi to release a copy of the school records for \_\_\_\_\_  
*(Name on Transcript)*  
to \_\_\_\_\_.  
*(self or name of other person/institution)*

*I agree to hold harmless the Diocese of Corpus Christi, the Roman Catholic Church, its subordinate Parishes, Bishops, clergy, and their successors in office, and all other persons and institutions connected with them from any liability for releasing this information pursuant to my request.*

\_\_\_\_\_  
*Authorization Signature (Required)*

\_\_\_\_\_  
*Date*

\*Note: The person authorizing release must be the person named in the record, the parent of a minor child, or the spouse or adult child if the person is deceased. Anyone else must show proof of power-of-attorney.

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NOTARIZATION: I, \_\_\_\_\_, Notary, do hereby certify  
*(print name of Notary)*

that the above named individual seeking the release of confidential information did appear before me in person with sufficient identification.

\_\_\_\_\_  
*(Notary Signature and Seal)*

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**Forwarding Information**

Send Records To:

Name/Institution: \_\_\_\_\_

Street: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Phone: \_\_\_\_\_

**For Office Use Only**

Received By: \_\_\_\_\_ Date: \_\_\_\_\_ Records Mailed: \_\_\_\_\_