Alexandria School of Scientific Therapeutics, Inc.
PO Box 287 / 809 S. Harrison St.
Alexandria, IN 46001
Phone: (765) 724-9152 / Fax: (765) 724-9156

Graduate Referral Release Form

PLEASE PRINT INFORMATION FOR OFFICE USE ONLY:

Graduate Name: _____

Home Address

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____**County:** _____

Massage Therapy Work Address

Street: _____

City: _____ **State:** _____ **Zip:** _____

Phone: _____**County:** _____

Fax #: _____

Email address: _____

INFORMATION FOR REFERRALS ONLY:

☐ **I give permission for my name and phone number to be released to individuals who may be looking for a massage therapist in my area.**
Phone number to be used for referral: _____

☐ **I give permission for my name and phone number to be released to prospective students that may call me and ask me questions pertaining to the school and my training.**
Phone number to be used for referral: _____

I understand that I may request in writing at any time for this information to be removed from the above listings.

☐ **I do not wish to have my name, phone number, fax number and email address used for any referral or referral material.**

Graduate Signature: _____**Date:**_____

***This is in accordance with the "Family Educational Rights And Privacy Act (Buckley Amendment)"*