**AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ hereby authorize \_\_\_\_\_\_\_\_\_\_\_, (the “Institution”) including all employees, agents, and other persons professionally affiliated with Institution having information related to the results of any clinical access information including, but not limited to, health records, background check, drug screen, and credential check(s) results to disclose the same to such hospitals, clinics and similar medical treatment facilities I am assigned for the purpose of clinical instruction or to which I am scheduled to be assigned, waiving all legal rights to confidentiality and privacy.

I expressly authorize disclosure of this information, and expressly release the Institution, its agents, employees, and representatives from any and all liability in connection with any statement made, documents produced, or information disclosed concerning the same.

I understand that a hospital, clinic and similar medical treatment facility (an “Affiliate”) may exclude me from clinical placement on the basis of the results of any of the clinical access information required by the Affiliate, including but not limited to my health records, the background check, drug screen, and credential check(s). I further understand that if I am excluded from clinical placement by an Affiliate, I may not be able to meet course requirements and/or the requirements for graduation. I release the Institution and its agents and employees from any and all liability in connection with any exclusion that results from information provided to an Affiliate hereunder.

Student Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date