

**MEMORIAL HEALTH UNIVERSITY MEDICAL CENTER, INC.  
STUDENT AUTHORIZATION FOR RELEASE OF  
CONFIDENTIAL RECORDS AND INFORMATION**

To: \_\_\_\_\_(hereinafter referred to as the "Institution"), and  
Memorial Health University Medical Center, Inc. (hereinafter referred to as the  
"Facility") where I participate in or request to participate in an applied learning  
experience.

RE: \_\_\_\_\_  
Print Student Name

As a condition of my participation in an applied learning experience and with respect thereto, I grant my permission and authorize the Institution to release my educational records and information in its possession, as deemed appropriate and necessary by the Institution, including but not limited to academic records and health information to the Facility where I participate in or request to participate in an applied learning experience. I further authorize the release of any information relative to my health to the Facility for purposes of verifying the information provided by me and determining my ability to perform my assignments in the applied learning experience. I also grant my permission to and authorize the Facility to release the above information to the Institution. The purpose of this release and disclosure is to allow the Facility and the Institution to exchange information about my medical history and about my performance in an applied learning experience.

I further understand that I may revoke this authorization at any time by providing written notice to the above stated person(s)/entities, except to the extent of any action(s) that has already been taken in accordance with this "Authorization for Release of Confidential Records and Information".

I further agree that this authorization will be valid throughout my participation in the applied learning experience. I further request that you do not disclose any information to any other person or entity without prior written authority from me to do so, unless disclosure is authorized or required by law. I understand that this authorization shall continue in force until revoked by me by providing written notice to the Institution and the Facility, except to the extent of any action(s) that has already been-taken in accordance with this "Authorization for Release of Confidential Records and Information".

In order to protect my privacy rights and interests, other than those specifically released above, I may elect to not have a witness to my signature below. However, if there is no witness to my signature below, I hereby waive and forfeit any right I might have to contest this release on the basis that there is no witness to my signature below.

Further, a copy or facsimile of this "Authorization for Release of Confidential Records and Information" may be accepted in lieu of the original.

I have read, or have had read to me, the above statements, and understand them as they apply to me. I hereby certify that I am eighteen (18) years of age or older, or my parent or guardian has signed below; that I am legally competent to execute this "Authorization for Release of Confidential Records and Information"; and that I, or my parent and/or guardian, have read carefully and understand the above "Authorization for Release of Confidential Records and Information"; and that I have freely and voluntarily signed this "Authorization for Release of Confidential Records and Information".

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Student Signature

Date

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Parent/ Guardian Signature