METROPOLITAN COMMUNITY COLLEGE

HEALTH PROFESSIONS PROGRAMS

STUDENT AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION TO A CLINICAL AFFILIATE

I, the undersigned, give the Health Professions' faculty at Metropolitan Community College the authority to release the following information to clinical affiliates in compliance with the clinical affiliation agreements and for the purpose of on boarding at clinical affiliate sites that the program uses:

• College email address	YES	NO
• Phone number	YES	NO
• Immunization records	YES	NO
• Mailing Address	YES	NO
• DOB	YES	NO

I understand that: (1) I have the right not to consent to release my contact information; my failure to consent may disallow me from a clinical site and therefore may result in failure to meet course objectives for clinical and program requirements (2) that this consent shall remain in effect until revoked by me, in writing, and delivered to the Program Director, but that any such revocation shall not affect disclosures previously made by a faculty member prior to his/her receipt of any such written revocation.

Student Signature ____

Student Printed Name ____

Parent/Guardian Signature ____

(if student is 19 years old or younger)

Date __________________