ARKANSAS STATE UNIVERSITY

AUTHORIZATION TO RELEASE INFORMATION

I am scheduled for clinical experiences outside of Arkansas State University. The institutions where I am scheduled to complete my clinical education require that the Arkansas State University Athletic Training Program release my phone number, social security number, immunization and PPD records, the results of my criminal background check, documentation of my HIPAA and OSHA education attendance before I begin clinical training.

Therefore, I authorize the Arkansas State University Athletic Training Program to release my phone number, social security number, immunization and PPD records, background check, and attendance records for HIPAA and OSHA education to the institutions where I am scheduled for clinical education.

This permission extends for the duration of my enrollment as a student at the Arkansas State University Athletic Training Program. I understand that I may withdraw this permission by notifying the Athletic Training Program's Clinical Coordinator in writing. However, withdrawal of this authorization will not affect information that has already been released.

I understand that withdrawing my permission may prevent my placement at outside clinical sites and prevent my completion of the Arkansas State University Athletic Training Program.

I understand that the information disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient institutions and may no longer be protected by federal regulations.

_____ _____

Student Signature Date

_____

Printed Student Name