

# Consent to Release Education Records: Clinical Partners



## OFFICE OF THE UNIVERSITY REGISTRAR

FIRST FLOOR, CHUBB HALL, 1 OHIO UNIVERSITY DRIVE, ATHENS, OH 45701-2979  
PHONE 740.593.4191 | FAX 740.593.0216 | EMAIL registrar@ohio.edu | WEB ohio.edu/registrar

**Description:** Form to allow Ohio University to share confidential information with externship/clinical sites

**Submit release to:** Academic College

**Who submits release:** Student to the academic department assisting with externships/clinical sites

**Student Name:** \_\_\_\_\_

**Student PID:** \_\_\_\_\_

I give Ohio University my consent to provide the confidential information indicated below to my Externship Site/Clinical Education Site(s) upon their request.

I further understand that (1) I have the right not to consent to the release of my education records; (2) I have the right to review such records upon request; and (3) this consent shall remain in effect until revoked by me, in writing, and delivered to Ohio University, but that any such revocation shall not affect disclosures previously made by Ohio University prior to the receipt of any such written revocation.

**Please indicate records to be released by checking all applicable boxes:**

Health History Medical Form \_\_\_\_\_

Drug Screening Results \_\_\_\_\_

Immunization Results \_\_\_\_\_

Exemptions Granted by Ohio University \_\_\_\_\_

Criminal Background Check Results \_\_\_\_\_

Professional Liability Insurance \_\_\_\_\_

CPR Certification \_\_\_\_\_

Academic Records \_\_\_\_\_

Clinical Hours Information \_\_\_\_\_

I understand that my Externship Site/Clinical Education Site may be required to disclose my COVID vaccination status, including any exemptions granted, to governmental agencies in accordance with the CMS COVID vaccine requirement. By consenting to the release of my COVID vaccination records to my Externship Site/Clinical Education Site, I further consent to my Externship Site/Clinical Education Site disclosing this information in accordance with the requirements of the CMS COVID vaccine requirement.

While I understand that I have the right not to consent to the release of my education records, I understand that failure to consent may prevent me from being placed for training opportunities, which in turn, may impact my progress through the curriculum and graduation.

**Student Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

OHIO UNIVERSITY OFFICE OF THE UNIVERSITY REGISTRAR USE ONLY

**Form approved/processed by:** \_\_\_\_\_

**Date:** \_\_\_\_\_