SCHOOL OF NURSING

Authorization For Release of Records and Information

TO: The Board of Regents of the University System of Georgia or any of its member Institutions (hereinafter referred to as the "Institution"), and any Facility where I may participate in an educational training program, including but not limited to any Georgia Hospital Association member Facility (hereinafter referred to as the "Facility")

RE: _____

(Print Name of Student)

As a condition of my participation in an educational training program and with respect thereto, I hereby waive my privacy rights, including but not limited to any rights pursuant to the Family Educational Rights and Privacy Act, 20 U.S.C. §1232g(b)(2)(B), and grant my permission and authorize The Board of Regents of the University System of Georgia or any of its member institutions to release any and all of my records and information in its possession, including but not limited to academic record and health information to any Facility where I may participate in an educational training program, including but not limited to any Georgia Hospital Association member Facility (hereinafter referred to as the "Facility"). I further authorize the release of any information relative to my medical history, physical and mental condition to the Facility for purposes of verifying the information provided by me and determining my ability to perform my assignments in the educational training program. 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 educational training program.

I further agree that this authorization will be valid throughout my educational training program. 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 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

Records and Information" may be accepted in lieu of the original.

By signing this "Authorization for Release of Records and Information", I hereby indemnify and hold harmless The Board of Regents of the University System of Georgia, its members, agents, servants and employees, The Board of Regents of the University System of Georgia member institutions and their respective members, agents, servants and employees, and the Facility and its members, agents, servants and employees (each of the foregoing being hereinafter referred to individually as the "Indemnified Party") against all claims, demands, causes of action, actions, judgments, or other liability including attorney's fees (other than liability solely the fault of the Indemnified Party) arising out of or in connection with this "Authorization for Release of Records and Information".

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, suffer under no legal disabilities, and that I have freely and voluntarily signed this "Authorization for Release of Records and Information".

This the _____day of _____, _____.

_____ _____

Signature Witness Signature

Name:_____ Name: _____

(Please Print) (Please Print)

_____ _____

Parent/Guardian Signature (if applicable) Witness Signature

Name:_____ Name:_____

(Please Print) (Please Print)

Return signed form via EMAIL to
nursing@gsw.edu, FAX to 229-931-2288,
or via mail to:

School of Nursing
Student Services Coordinator
Georgia Southwestern State University
800 Georgia Southwestern State University Drive
Americus, GA 31709