



Please complete all information below. Incomplete forms will result in processing delays.

_____		_____		_____	
Student ID or SSN		Date of Birth		Contact Phone (very important)	

Last Name		First Name		Middle Name	Former Name (s)

Current Mailing Address (required)			City	State	Zip

E-Mail					

Degree Program		School/Program Enrolled In (i.e.: Graduate Nursing, Medical School etc.)			

Information Authorized for Release.

OHSU is hereby authorized to release the following educational records and information listed below:

- (1) No Restriction

Purpose.

The Information listed above may only be released to

Send To:

Release.

I understand that (1) have the right not to consent to the release of my educational records; (2) I have the right to receive a copy of such records upon request; and (3) that this consent shall remain in effect until revoked by me, in writing, and delivered to the OHSU Register's Office, but that any such revocation shall not affect disclosures previously made by OHSU prior to the receipt of any such written revocation.

I authorize OHSU to release my educational records and information as indicated above:

Student Signature (required - unsigned requests will not be processed)

Date

THIS INFORMATION IS RELEASED SUBJECT TO THE CONFIDENTIALITY PROVISIONS OF APPROPRIATE STATE AND FEDERAL LAWS AND REGULATIONS WHICH PROHIBIT ANY FURTHER DISCLOSURE OF THIS INFORMATION WITHOUT THE SPECIFIC WRITTEN CONSENT OF THE PERSON TO WHOM IT PERTAINS, OR AS OTHERWISE PERMITTED BY SUCH REGULATIONS.