



OHSU School of Nursing Release of Information

Full Name: _____ Date: _____

Academic Program _____ Anticipated Graduation Date: _____

Permission to Release Information *Please initial the following:*

- I authorize the Office of Academic Affairs or its designee, to release evaluation information from my student file for the purposes of writing letters of recommendation for scholarships.
- I authorize the Office of Academic Affairs to post my name indicating that my GPA was sufficient to qualify for achievement recognition. I understand that my exact GPA will not be disclosed.
- I authorize the Office of Academic Affairs to release information about my achievements, special recognition or involvement in community/professional activities.
- I authorize the Office of Academic Affairs, or its designee, to release student phone numbers for use to follow up with clinical agency business. You are not required to give out this information. If you do not wish to disclose this information, please cross out the blank for the number and sign your name. **You must make alternative arrangements with your clinical advisor if not disclosing this information.**

Contact Phone Number: _____

Family Education and Privacy Act (Buckley Amendment) states it is a violation of federal and state law to release any information regarding an individual student without the student's written consent.

Please return this form to:

**Office of Admissions
OHSU School of Nursing :SN-ADM
3455 SW US Veteran Hospital Road
Portland OR 97239-2941**