THE UNIVERSITY OF ARIZONA COLLEGE OF MEDICINE - PHOENIX
AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name: **Last, First, Middle**	**Student ID Number:**

In connection with my participation in programs sponsored by The University of Arizona College of Medicine - Phoenix, (COM-P), including clinical rotations at any and all sites with which COM-P has established affiliation agreements, I hereby consent to access and disclosure of information in my educational records to such affiliates to enable such affiliates to verify information required for accreditation purposes or for purposes expressly stated in such agreements, including to verify my standing with COM-P. Access is limited to the following information, if required, *which is a part of my education records:*

- Fingerprint Clearance Card
- Affiliate Institution's Application
- Unofficial Transcripts from COM-P
- Photo Identification *(e.g.,* CatCard or Driver's License)
- Social Security Number*
- Proof of Health Insurance
- Unofficial USMLE Board Scores (Steps I and II)
- CPR certification
- Proof of compliance indicating immunization records are up to date. Please note: UACOM-P will not view or send immunization records on behalf of students
- E-mail address, phone number, pager number and home address, emergency contact information
- Online HIPAA/OSHA and Site Specific Affiliate Orientation Materials
- Letter verifying my good standing in the COM-P (verifying matriculation and anticipated graduation date, completion of HIPAA and universal precautions training, unofficial USMLE scores, and malpractice coverage through Arizona State Risk Management)

I understand that these records may be protected under the Family Educational Rights and Privacy Act of 1974, as amended, and may not be released without my written permission. I hereby waive all provisions of law and privilege relating to the records described in this authorization. I certify that this consent has been given freely and voluntarily. I may revoke this authorization or change the date of expiration at any time by providing written notice of such revocation to the University office or person who maintains records of this authorization. **This authorization shall remain continuously in effect until I withdraw this authorization in writing or for the duration of my enrollment at COM-P, whichever first occurs.**

Photocopies, scans or facsimiles of this release form may be accepted. The person and/or agency receiving this information may not further disclose the information received as a result of this disclosure unless specifically authorized for the purposes as stated in this release or upon my further authorization. The information must be destroyed when no longer needed for the specified purpose.

*I further understand that COM-P has requested my Social Security Number and will disclose that number to its affiliates to allow me access to the affiliates' medical records and other systems. In accordance with Section 7(b) of the 1974 Privacy Act (Public Law 93-579), I hereby consent to the collection of this information and its disclosure for the stated purpose. I understand my disclosure of this information is voluntary. Should I choose not to disclose my Social Security Number, I understand that the clinical rotation site may be unable to provide me access to their medical records and other systems.

I understand that if I do not wish to have any of the information listed above be subject to disclosure under this release, I shall notify the Dean of Students Office at the College of Medicine – Phoenix in writing as well as identify the information type that I do not wish to be subject to disclosure.

Student Signature	Date