University of Connecticut School of Nursing Student Authorization/Consent For Disclosure of Protected Information

I understand that my personal health information is protected under the Family Educational Rights and Privacy Act (FERPA) and/or Connecticut state law, and may not be disclosed without my permission, except in limited circumstances as permitted or required by law.

By signing this form, I authorize the University of Connecticut to disclose certain information identified below as required for me to participate in clinical learning experiences.

By initialing the spaces below, I specifically authorize the use or disclosure of the following health information:

- ☐ Immunization reports, titers or documentation of disease incidence for measles, mumps, rubella, varicella, tetanus-diphtheria (within 10 years) and hepatitis B;
- ☐ Meningococcal vaccine and flu vaccine;
- ☐ Physical examination including urinalysis and blood work for Hemoglobin and Hematocrit
- ☐ Tuberculosis blood tests or TB skin tests;
- ☐ Influenza, if applicable.

The following items must be initialed to be included in this request for use or disclosure:

- ☐ HIV/AIDS related information
- ☐ Mental health information
- ☐ Drug screening information
- ☐ Drug & Alcohol treatment information
- ☐ Background Check information
- ☐ Fingerprinting information

I am signing this authorization/consent form voluntarily. I understand that I have a right to revoke my authorization/consent in writing at any time, except to the extent that the University of Connecticut School of Nursing has acted in reliance upon this authorization. My written revocation must be submitted to:

Betty Garrison
Secretary 1
Admission & Enrollment Services
Storrs Hall, Room WW17
231 Glenbrook Road
Storrs, CT 06269-2026
Phone (860) 486-1968
Fax (860) 486-0906

. This authorization will remain in effect for the duration of your nursing program.

Student Signature: ____

Name of Student: ____

Student Identification Number: ____________________________________

Address: ____