

COLLEGE OF SOUTHERN NEVADA

AUTHORIZATION TO RELEASE INFORMATION

Student (PRINT name) _____

Date of Birth _____

As a student enrolled at the College of Southern Nevada (CSN), I give permission for CSN to release the following information from my student records:

- _____ Immunization records
- _____ Health insurance card
- _____ CPR card
- _____ Drug Screen Results
- _____ Other (please specify) _____

This information can be released to:

Name _____
Address _____
City/State and Zip _____

This information is requested for the purpose(s) of:

- _____ Recruitment
- _____ Employment
- _____ Clinical affiliation requirements
- _____ Other (please specify) _____

This authorization is valid for two (2) years and may be revoked at any time. Revocation of this authorization must be made in writing to CSN. CSN is not liable for release made prior to revocation.

Student Signature

Date

PRINT Student Name

Student ID Number

Copy to: program director