DREXEL UNIVERSITY
College of
Nursing and
Health Professions

AUTHORIZATION TO DISCLOSE INFORMATION
(Family Educational Rights and Privacy Act)

Name: *(please print)* _____ Date: _____

University ID: _____

Program: *(please check one)*

☐ ACE ☐ Co-op ☐ RN-BSN ☐ MSN ☐ DrNP ☐ NUAN ☐ PA ☐ PTRS

☐ HSAD ☐ HSCI ☐ NS/ISPP ☐ BHC ☐ CFT ☐ CAT ☐ RT

I understand that my program at Drexel University includes a clinical component that may occur at an off-campus medical facility or clinic that is not part of the University. I also understand that during this clinical component it may be necessary for the University and the Clinical Site to exchange certain records about me. Therefore, I hereby authorize the University to disclose the following records about me:

- Any education record maintained about me by the University, including transcripts and grade reports, academic and clinical evaluations, health records, and disciplinary records.

To personnel at any Clinical Site:

- Who are responsible for considering my placement at that Clinical Site, or
- Who will supervise or participate in my education at that Clinical Site

For the following purpose(s):

- To determine whether or not to accept me for placement at that Clinical Site;
- To plan, manage, or supervise my educational program at the Clinical Site; or
- To evaluate my academic progress at the Clinical Site or the University.

Signature of Student: _____

The Family Educational Rights and Privacy Act (FERPA) provides for the confidentiality of student education records. Institutions may not disclose information about students nor permit inspection of their records without their permission unless such action is covered by certain exceptions as stipulated in the Act.

The student may cancel this authorization at any time by providing written notification to the university official listed above.