LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

Student Authorization to Release Information to Clinical Agencies

Student Information (Please Print)

Name: _____ Liberty Student ID: L_____

SS # (Last four digits ONLY): ____ ____ ____ ____ Date of Birth(mm/dd/yy):____/____/____

Email: _____@liberty.edu Phone Number: (_____) _____-_____

Release Information (Please Print)

Information that may be released:

Documentation of Immunizations and Tests,
Copies of CPR and First Aid Cards,
Contact Information (address, phone number, email),
Copy of Background Check,
Academic Standing,
Copy of Drug Screening Results,
Date of Birth,
Social Security Number,
LUID Number

I authorize Liberty University College of Osteopathic Medicine to release the above information from my student file for placement and clearance to affiliated hospitals and clinics. I understand that I may be asked for additional information from clinical agencies or in some cases cannot be placed at certain sites due to the sites' requirements.

The Family Educational Rights and Privacy Act (FERPA) sets forth requirements regarding the privacy of student records. FERPA regulations allow you, the student, to have some control over who is allowed to have access to your school records and personal information. For further information about FERPA, please see the Liberty University College of Osteopathic (LUCOM) FERPA Policy and Release Information.

Authorization (Please Print & Sign)

Student's Signature:_____ **Date:**_____

**By signing this form you authorize the LUCOM to release your record information to affiliated hospitals and clinics.*

This authorization is valid for a period of ten (10) years from the date of signature and may be revoked at any time by written notice to the Dean of the Liberty University College of Osteopathic Medicine.

When complete, submit this form to the Office of Admissions and Student Services. (LUCOMAdmisisons@liberty.edu)

Official Use Only *Processed By:*_____ *Date:*_____