PIKES PEAK STATE COLLEGE

Health Sciences Clinical Compliance

STUDENT CONSENT FOR RELEASE OF RECORDS

Name: _____ S# _____

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my educational records cannot be released without my written permission.

I, therefore, request that the information listed below be released by:

Pikes Peak State College Health Sciences Clinical Compliance Services

Information to be released to: ____Community Partners for Clinical Rotations_____

_____

Copy of Drug Test Result ☐ Yes ☐ No

Copy of Background Check Result ☐ Yes ☐ No

Purpose: ☐ Student Enrollment/Internship

Signed this _____day of _____, _____.

_____
Signature of Student

_____
Signature of Pikes Peak State College Clinical Compliance Employee