AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize The American University of Kurdistan and/or its employees in the College of Nursing responsible for reviewing Clinical Healthcare Requirements to release confidential information such as immunization records, required forms, background check information, grades, academic progress reports, or class attendance reports to the person(s) listed herein. I further understand that the authorization is valid as long as I am enrolled at AUK or until a written statement from me requesting that the release of confidential information be canceled.

Finally, I understand that my confidential information will only be released upon receipt of a request for specific information and that I may cancel this "Student Consent to Release Confidential Information Form" by submitting a written statement in person at any time to:

College of Nursing (CoN), #227-1, Wing C, 2nd Floor

Persons of whom my confidential information may be released to:

- Clinical Healthcare Facility where I am scheduled to do my clinical(s)

Student's Required Information:

Student Printed Name: _____

Student Signature: _____ Date: _____

Note: Submit this form to the CoN office. Your registration is not complete until the signed form has been received.