RANKEN
TECHNICAL COLLEGE

CONSENT FOR RELEASE OF INFORMATION
TO FACILITATE COMMUNICATION
IN ORDER TO COORDINATE SERVICES

I, _____, do hereby authorize and consent to the release and disclosure of information in the form of written documentation and records as well as verbal disclosures between relevant healthcare providers and staff within Ranken Technical College and:

Medical Treatment Provider: _____

Phone/Fax: _____

Address: _____

Medical Treatment Provider: _____

Phone/Fax: _____

Address: _____

Medical Treatment Provider: _____

Phone/Fax: _____

Address: _____

Other: _____

Other: _____

Other: _____

Restrictions on Release of Information: _____

_____

_____

Time Limit: I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. **Unless otherwise revoked, this authorization will expire:**

- ☐ 12 months from the date hereof
- ☐ Upon my departure from Ranken Technical College
- ☐ Other: _____

I hereby release Ranken Technical College, its employees, agents, and staff members who may participate in this disclosure from any right or claim that I might otherwise have for damages or other liability which might arise out of or result from disclosures authorized by signing this release. I understand that I have a right to a copy of this release of information. I understand I may refuse to sign this release of information. My refusal will not affect my ability to obtain services.

_____ _____

Student Name (Print) Date

_____ _____

Student Signature Date