

AUTHORIZATION/REQUEST FOR ACCESS TO STUDENT RECORDS

Student Name _____ Student I.D. Number _____

_____ Phone _____ Student Status: Current
Former

Record Requested

Purpose(s) of Disclosure _____

Person to whom access is granted (if other than student) _____

Date Student's Signature

Medical or psychological records relating to treatment received at Student Health and Psychological Services may not be reviewed directly by the student. Instead, a medical doctor or other appropriate professional must be authorized to conduct that review.

Information placed in a student's Professional Placement File prior to January 1, 1975, with an understanding, expressed or implied, that it was not to be made available to or seen by the student concerned, may not be reviewed directly by the student.

NOTE: This form is to be used unless a similar authorization is personally developed and submitted by student.

