PHYSICIAN ASSISTANT PROGRAM

STUDENT RELEASE AGREEMENT

This form provides the authorization necessary for the release of information described below.

I understand that the Health Professions Department must maintain student records and distribute proof of health requirements, CPR, and criminal background information about students to required clinical agencies to meet required standards. I also understand that the Health Professions Department must report aggregate student data to accrediting bodies, and may utilize student data for self study/ or research purposes.

In light of these expectations, I hereby agree:

- To the release and distribution of my individual proof of health requirements, ACLS and CPR certification to clinical agencies as required by OSHA and JACHO.
- To the release of information obtained through criminal history search to health care agencies in accordance with the Caregiver Law (Wisconsin Act 27) enacted October 1, 1998.
- To the release of the last 4 digits of my social security number if required by a clinical agency.
- To the use of aggregate student data for self-study/research and accreditation purposes. I understand that no identification of my individual data will be permitted.
- To the release of photographs and videotaped clips of classroom, laboratory, volunteer, and clinical activities may occur that would involve pictures and videotape clips of me as a participant in these educational activities. I agree to the use of any pictures and videotaped segments for future program needs-including educational and marketing needs of the program or university.
- To the destruction of my personal unofficial student records including health information and background checks in 3 years from the date of graduation from the Health Professions Department.

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Student's Signature Date

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Student's Printed Name