



## University of Maryland School of Pharmacy Consent for Release of Student Information

**Date**

I, \_\_\_\_\_, hereby authorize  
*Student Name*

\_\_\_\_\_, to release the  
*Name of Person or Program Making the Disclosure*

following information: \_\_\_\_\_

\_\_\_\_\_

to \_\_\_\_\_.

The purpose of the information is as follows: \_\_\_\_\_

\_\_\_\_\_.

I understand that my records are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may withdraw my permission for the use of this information at any time, except to the extent that action has been taken in reliance on it (e.g. rotations, probation, etc.). It is my understanding that this consent expires automatically as described below:

Date, event, or condition upon which this consent expires: \_\_\_\_\_

\_\_\_\_\_.

\_\_\_\_\_  
*Signature of Student*

\_\_\_\_\_  
*Signature of Witness*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Date*