William Paterson University
Clinical Student Request and Authorization to Release Records and/or Information

This form when completed and signed by you authorizes the School of Nursing Department, to release protected information from your clinical record to the person or agency you designate.

I,_____, authorize the School of Nursing
(Print name of student)

and administrative staff, and Exxat to release information to one another regarding my clinical physical and any relevant information related to participation in the nursing program at William Paterson University.

The records are to be discussed verbally, via fax, or via email for the purpose of coordination of care. This authorization shall remain in effect for one year from the date signed below (unless otherwise indicated).

I understand that I have the right to revoke this authorization in writing, at any time by uploading such written notification to Exxat.

However, my revocation will not be effective to the extent that we have taken action in reliance on the authorization or if this authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to the authorization may be subject to redisclosure by the recipient of my information and no longer protected by the HIPAA Privacy Rule.

_____ _____

Student ID# Date of Birth

_____ _____

Signature of student (*parent if minor)* Date

Revised Sept. 2023