Authorization for Release of Information

Division of Student Life
Notre Dame of Maryland University Baltimore, Maryland 21210
studentlife@ndm.edu; (410) 532-5308

For University Use Only
UID#
Staff Initials
Date Received

TO BE COMPLETED BY STUDENT/LEGAL GUARDIAN/PERSONAL REPRESENTATIVE. Print legibly in blue or black ink.

Name (Last) _____ (First) _____ (Middle) _____

University ID# _____ Date of Birth ____/____/____ College: Women's ____ CAUS _____ Graduate ___

Student Status: Resident ❑ Commuter ❑ International (If so, Country of Origin) _____
School: Arts&Sciences_____ Education_____ Nursing_____ Pharmacy _____

Perminent Address _____

Cell Phone _____ Email Address_____

I, _____ hereby authorize Notre Dame of Maryland University and its Division of
(Student Full Name)
Student Life to release my immunization records to:

Name _____

Address_____

Phone _____ Fax _____

OR to the following Notre Dame of Maryland University Schools and/or departments:

❑ School of Arts and Sciences ❑ School of Nursing ❑ Other NDMU Department
❑ School of Education ❑ School of Pharmacy If so, please list the specific department below:
_____

Purpose of Disclosure

❑ Admittance into Program/University ❑ Insurance ❑ Other (Please specify.)
❑ Changing of Physicians ❑ At my request (You are not required to provide a reason.) _____

Acknowledgement of Policies and Terms

I understand that if Notre Dame of Maryland University has requested this authorization that I will receive a copy of this document once completed and signed.
I understand that this authorization will be valid for one academic year.
I understand that I might revoke this authorization at any time by notifying the Division of Student Life in writing that is sent to studentlife@ndm.edu, and it will be effective on the date received except to the extent action has already been taken in reliance upon it.
I understand that information disclosed to the above individual or Notre Dame of Maryland University School, program, or department may be redisclosed and not protected by the Federal Privacy Act.
I understand that vaccination forms and other health history information submitted to the Division of Student Life will be held on file only while enrolled as a student at Notre Dame of Maryland University. Upon graduation or should I no longer be enrolled at the University, this information will no longer be held on file within the Division of Student Life.

By signing this document, I agree to the policies and terms listed above and authorize release of information to the above noted individual or NDMU University Schoo, program or department.

Student Full Name (Printed)_____

Student/Legal Guardian/Personal Representative Signature_____
If signed by anyone other than the student, please state relationship to student and print full name:
_____