

Authorization for the Release of Student Background Study Information

This form is located on the Affirmative Action Office web site (www.mnstate.edu/affirm) and can be completed on-line. Once completed, it must be printed for signatures. Hard copies are also available from the university department that is in charge of the internship/clinical.

To Whom It May Concern:

I, _____, hereby authorize

Minnesota State University Moorhead
1104 7th Avenue South
Moorhead, Minnesota 56563

to release information contained in its files (including but not limited to reports, records and letters or copies thereof) regarding a background study performed by the Minnesota Department of Human Services, or a request to the Minnesota Commissioner of Health for reconsideration of a disqualification, to determine my eligibility to participate in clinical placements to fulfill the requirements of the _____ program at Minnesota State University Moorhead. This information may be released to the faculty member in charge of my placement in the clinical program and to the following facilities:

(Name of faculty supervisor) _____
(Name of Department) _____
(Name of site facility) _____
(Name of site supervisor) _____
(Address of site supervisor) _____
(City, state, zip code of site supervisor) _____
(Telephone number of site supervisor) _____

This information may also be released to other facilities requesting the information and who are involved in my clinical placement.

I understand that the facility will review this information to assess whether I may be permitted to participate in a clinical placement in its _____ program.

I understand that I am not legally obligated to provide this information. If I do provide it, the data will be considered private data under state and federal law, and released only in accordance with those laws, or with my consent. I provide this information voluntarily and understand that I may revoke this consent at any time. A photocopy of this authorization may be used in the same manner and with the same affect as the original documents. This authorization expires one year from the date of my signature.

Date: _____ (Signature of student) _____
(Address) _____
(City, state, zip code) _____
(Telephone number, including area code) _____

Faculty Verification:

I _____ (Signature of faculty member in charge of placement)
verify that the placement information included on this authorization form is correct.

(Date) _____