UNIVERSITY OF THE DISTRICT OF COLUMBIA
COMMUNITY COLLEGE

RESPIRATORY THERAPY PROGRAM

COMMUNITY COLLEGE
DIVISION OF ALLIED HEALTH, LIFE & PHYSICAL SCIENCES

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

STUDENT NAME: _____ ID #: _____

I, _____(student name), hereby authorize the Respiratory Therapy Program faculty and the UDC Health Services staff, if necessary, to release my medical information to any clinical affiliates. I understand that in order to participate in clinical activities, I must first obtain health clearance from UDC Health Services, and that at any given time, clinical affiliates may request documentation that proves my health clearance.

This authorizations applies to any medical information that I volunteered released to the Respiratory Therapy Program faculty and to the UDC Health Services staff, such as, vaccination records, drug screen results, TB status information, any lab results, chest xray results and physical assessment information.

I understand that to maintain my clearance status at any clinical affiliate, my medical information may be shared with the hospital that I am currently or will be participating in clinical activities.

This authorization is valid as long as I am in the Respiratory Therapy Program.

_____ _____
Student signature **Date**

_____ _____
Witness Name & Signature **Date**

_____ _____
Prof. Tanya Claggett, MA RRT **Date**
Director of Clinical Education
Respiratory Therapy Program