JOHNS HOPKINS
SCHOOL of NURSING

STUDENT AUTHORIZATION TO RELEASE EDUCATION RECORD FORM

Student Name: _____ Date of Birth: _____
(Please Print)

I understand that the Family Educational Rights and Privacy Act (FERPA) protects the confidentiality of my student education records and that the Johns Hopkins University and the School of Nursing may only release these records to third parties with my prior written consent or as otherwise permitted by law. Intending to waive my right of confidentiality, I consent and direct the Johns Hopkins University School of Nursing to release information from my education records to the following person/agency:

Name of person/agency to receive information:

Address:

Telephone number:

I, the undersigned, hereby authorize the Johns Hopkins University School of Nursing to release the following Supporting Nursing Advanced Practice Transitions (SNAPT) Fellowship educational records and information: my application, essay, CV/resume, letters of recommendation, rating forms, memorandum of understanding, or any other educational record of pertinence that relates to my participation in the SNAPT Program.

I understand these student records are being released for the sole purpose of SNAPT partners evaluating my student application package to determine if there is interest in my candidacy for a SNAPT Fellowship position at the SNAPT partner's facility.

I understand further that (1) I have the right not to consent to the release of my education records; (2) I have the right to receive a copy of such records upon request; and (3) that this consent shall remain in effect until revoked by me, in writing, but that any such revocation shall not affect disclosures previously made by the Johns Hopkins University School of Nursing prior to the receipt of any such written revocation.

By signing below, I hereby authorize the Johns Hopkins University School of Nursing to release my education record information as specified above. Further, I agree to release, indemnify, and hold harmless the Johns Hopkins University, the School of Nursing, its employees, officers, and agents, from all liability for damages of whatever kind which may result on account of the Johns Hopkins University's compliance, or any attempts to comply, with this authorization.

Student's Signature: Effective Date: _

Student's Address: Cell #: _

Special Note to Recipient of the Education Record:
Please be advised that the recipient of records under this authorization may not re-disclose information from education records without the prior written consent of the student or as permitted by law.