Radiation Therapy Program

University of Iowa Hospitals and Clinics
Department of Radiation Oncology

STUDENT CONSENT FOR RELEASE OF RECORDS

TO: Radiation Therapy Education
University of Iowa Hospitals and Clinics
Radiation Oncology, 01521 PFPW
200 Hawkins Drive
Iowa City, IA 52242

FROM:____
Name of Student   Social Security Number

____
Street Address   City   State   Zip

Under Federal legislation, namely the Family Educational Rights and Privacy Act of 1974, I understand that my education records cannot be released without my written permission or a Parental Affidavit of Dependency certified by my parent or guardian.
I, therefore, request that the information listed below be released to the following:

____
Name

____
Street Address   City   State   Zip

Information to be released:
____

____

Purpose: ____

Signed this _________ day of ____________________, ____________