



The University of Iowa Hospitals and Clinics
Department of Radiology
Radiologic Technology Education

STUDENT CONSENT FOR RELEASE OF RECORDS

TO: Radiologic Technology Education
University of Iowa Hospitals and Clinics
Radiology, C723-GH
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 _____, _____