AUTHORIZATION TO RELEASE INFORMATION

Community Health Worker (CHW) Students

The Family Educational Rights and Privacy Act (FERPA) protects student confidentiality by placing certain restrictions on the disclosure of information contained in a student's education records. By signing this form, you agree that university personnel may provide information from your education records as indicated below.

Name of Student: _____ DOB: _____

I, the undersigned, authorize Cleveland State University to release the following educational records and/or any information contained therein:

- Name
- University/College Name
- Health Professional Discipline
- Specialty/Sub-Specialty Areas
- Retention Commitment Length
- Financial Award Amount
- Race/Ethnicity
- Gender
- Current Practice Location
- High School Zipcode
- Type of community you grew up in (rural, urban, suburban)

For the purpose of evaluating the Centers for Disease Control: Racial Ethnic Approaches to Community Health (REACH) Program and for the Ohio Board of Nursing Certification.

I understand and acknowledge that: (1) I have the right not to consent to the release of my education records; and (2) this consent shall remain in effect until revoked by me, in writing, and delivered to Cleveland State University, but that any such revocation shall not affect disclosures made prior to the receipt of any such written revocation.

_____

Student's Signature Date