



CALIFORNIA STATE UNIVERSITY, LONG BEACH

Nursing Department

HIPPA Student Release Form

I, _____
(Print your complete name)

hereby authorize the release of any medical information that I have disclosed to the Department of Nursing for the purposes of meeting the requirements of any and all clinical agencies to which I may be assigned. I am also acknowledging that I have received a copy of the HIPPA policy.

Today's Date

Signature

Witness