42 CFR – Part 2 and CFR Parts 160 & 164
RECORDS RELEASE AUTHORIZATION PHARMACY SCHOOL REPRESENTATIVE

I, _____, give my consent to

_____

(Pharmacy School Representative name, address, phone number)

to disclose information from my university records to **S.A.R.P.H.** for the sole purpose of maintaining my participation in the **S.A.R.P.H.** program in good standing through monitoring of my treatment, recovery and academic process.

I understand that the information disclosed will be used solely for the purpose of verifying and monitoring treatment and recovery, in order to determine my eligibility for continued participation in the Doctorate of Pharmacy Program and the **S.A.R.P.H.** Program. The information will be limited to Academic Performance Reports and any other information relevant to my behavior/functioning as a student and a competent Pharmacy Intern.

I understand that I have no obligations whatsoever to disclose any information from my S.A.R.P.H. record and that I may revoke this consent at any time except to the extent that action has been taken in reliance thereon, by notifying S.A.R.P.H. in writing; specifying the effective date of revocation. Without such notice of revocation, this consent shall automatically expire upon termination of my involvement in the S.A.R.P.H. program or upon graduation.

_____ _____

DATE SIGNED PARTICIPANT SIGNATURE

_____ _____

DATE SIGNED WITNESS SIGNATURE

Revised 5-27-15 KS