Ohio Institute of Allied Health
School of Integrative Healthcare

# FERPA Release Form

In accordance with the Family Educational Rights and Privacy Act of 1974 (FERPA), I, the undersigned student, hereby permits Ohio Institute of Allied Health to disclose the information specified below to the following:

Name: _____ Name: _____

**Check the box to indicate which records. You may also decline at this time.**

- ☐ **All College Records**
  - ☐ **All Financial Aid Records** (e.g. status of file, award and disbursement of funds information, SAP status, income information, and any other information contained in the application or financial aid file).
  - ☐ **All Academic/Transcript Records** (e.g. transcripts, admission and registration information, schedule documentation contained in the academic records).
  - ☐ **All Student Account Records** (e.g. amount for tuition and fees, sources of payment for tuition and fees, refund information, records hold information as it relates to parking tickets, library fines, financial aid repayments and any other accounts receivable information contained in student account records.)
  - ☐ **Instructor/Classroom Records** (e.g. attendance, progress reports, and grade, if available.) Please note: FERPA pertains to the release of official records. Instructors are not required to release attendance, discuss progress with anyone other than the student or provide progress reports.
- ☐ **I decline to release any student information to anyone other than myself.**

Records for counseling and services for students with disabilities are considered medical records and are not covered under FERPA rules, (require a separate release). I understand the information may be released orally or in the form of copies of written records, as preferred by the requester. This authorization will remain in effect from the date it is executed until revoked by me, in writing, and delivered to the Department(s) identified above.

Signature: _____ Date: _____

# Security and Confidentiality

**As a student at OIAH, and as a condition of my enrollments, I agree to the following:**

- □ I am responsible for complying with all HIPAA policies in class, lab and Clinicals during my time as a student, or upon cessation of enrollment for any reason.
- □ Clinical sites I may have additional uniform, conduct or confidentiality requirements. I am responsible for obtaining said requirements and staying up to date on policies.
- □ I will treat all information received during my enrollment at the OIAH as confidential and privileged information.
- □ I will not use email to transmit information unless I am instructed by the Privacy Officer at the institution. Nor will I remove patient information from the premises of any healthcare facility in paper or electronic form.

*I understand that violation of this agreement could result in disciplinary actions including termination.*

Signature: _____ Date: _____