

# Student Authorization to Release Information to Clinical Agencies

I authorize Washington State University College of Pharmacy and Pharmaceutical Sciences to release information from my education record as requested by clinical agencies in order to attempt to secure placement for clinical/practicum experiences.

I understand clinical agencies can require that I provide additional information beyond what is contained in my WSU education record.

I acknowledge there is no guarantee that I will receive a clinical placement. I understand I will not be placed at a clinical agency if I cannot meet the agency's requirements.

This authorization is valid for a period of five (5) years from the date of my signature. I understand I may revoke this authorization at any time by providing written notice to the Office of Experiential Services in the College of Pharmacy and Pharmaceutical Sciences.

Printed Name: \_\_\_\_\_  
*(First) (MI) (Last)*

WSU ID: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Signature: \_\_\_\_\_  
*Signature Date*

(AG R/V) Rev 3/18



College of Pharmacy and Pharmaceutical Sciences