 ***Department of Physical Therapy***

**Consent to Disclose Personal Information**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize Campbell University, Incorporated, by and through the Doctor of Physical Therapy Program within the College of Pharmacy and Health Sciences to disclose the following personal information about me to its affiliated healthcare institutions:

* Contact Information (Name, E-Mail, Biosketch including Photo)
* Personal health information to include only the following:
	+ Immunization Records
	+ Annual PPD results
	+ Proof of Annual Flu Shot
	+ Drug Screen Results
* Results of my Criminal Background Check
* Social Security Number (*for those sites that require this information for credentialing*)

I understand that this personal information will only be used for the purposes of credentialing and scheduling of clinical rotations so that I may be able to gain access to affiliated health/medical institutions in an effort to serve my clinical rotations required for completion of physical therapy school.

Furthermore, I hereby authorize Campbell University, Incorporated, by and through the Doctor of Physical Therapy Program within the College of Pharmacy and Health Sciences to disclose related academic or professional behavior information about me to clinical instructors and clinical coordinators directly involved in my clinical experiences or internship at its affiliated healthcare institutions:

Please read each statement below. If you understand and agree to these terms, please initial by each statement.

\_\_\_\_\_ I understand that I can refuse to sign this consent form.

\_\_\_\_\_ I understand that refusal to share these records could result in my inability to complete required clinical experiences at Campbell University DPT Program affiliated sites.

\_\_\_\_\_ I understand that this consent is valid for the duration of enrollment in the DPT Program.

\_\_\_\_\_ I understand that if I wish to withdraw consent after signing this form, I must submit my official request to discontinue “Consent to Disclose” in email to the Clinical Education Coordinator, Jennifer Shewmaker at jshewmaker@campbell.edu.

I understand that this personal information will only be used for the purposes of guiding student specific learning needs and developing professional behaviors to entry-level as required for successful completion of clinical experiences at affiliated health/medical institutions in an effort to successfully complete degree requirements.

Personal health information, academic or professional behavior information includes a copy of your immunization record, TB test results and/or chest x-ray results, drug screening results, criminal back ground check information as required by each clinical institution, and relevant professionalism or academic records and you waive any rights regarding the release of said information under the Family Education Rights and Privacy Act (FERPA) (20 USC 1232g, *et seq*.). Campbell University shall comply with all applicable laws, rules, and regulations relating to the procurement, use, storage, disclosure, privacy, confidentiality, security, or destruction of personally identifiable information, public records information, consumer reports, or investigative consumer reports, specifically including, without limitation, all applicable provisions of the Fair Credit Reporting Act, 15 U.S.C. § 1681 et seq., and the regulations promulgated thereunder, including, without limitation, providing a final adverse action notice to the consumer if a final adverse decision is made. You have the right to, within a reasonable period of time after the receipt of the disclosure by Campbell University, to receive a complete and accurate disclosure of the nature and scope of the investigation requested.

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Print Name

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Signature Date