



**USC**  
**College Of Nursing**  
**Office of Undergraduate Studies**  
**Phone: (803)777-7412 Fax: (803)777-0616**



**Release of Student Information**

Academic Information

Health Information

Full Name (Last, First, MI)

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Social Security Number

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I give consent to the College of Nursing to release information from my aforementioned records to the following person or agency.

Name of Person/Agency

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Position/Title

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Address

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\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date