



**GOOD SAMARITAN COLLEGE  
OF NURSING AND HEALTH SCIENCE**

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**PERMISSION TO RELEASE EDUCATION RECORD INFORMATION**

I give permission for the Good Samaritan College of Nursing and Health Science to release my

Clinical performance information

Academic record information

Education record information to be released: \_\_\_\_\_

to \_\_\_\_\_  
(full name)

\_\_\_\_\_ (complete address including city, state and zip)

for (purpose) \_\_\_\_\_

Student Name \_\_\_\_\_ Date \_\_\_\_\_  
(please print)

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

Action taken \_\_\_\_\_  
(by whom) (Date)