GOOD SAMARITAN COLLEGE
OF NURSING AND HEALTH SCIENCE

REQUEST TO REVIEW EDUCATION RECORDS

Date:_____

Name of Student:_____

Student ID Number:_____

Purpose of Review: _____

_____

Item(s) of Information Requested: _____

_____

_____

Name of Requestor:_____

Requestor's Affiliation: _____

I hereby agree to keep the information disclosed to me confidential according to applicable legislation and regulations.

Signature_____ Date_____

Disposition of Request: _____ Approved
_____ Disapproved

Specify Materials Reviewed (Records, Types of Information)_____

_____

_____

Signature of Official Approving Request_____ Date_____

Name and Title of Official Supervising Review_____ Date_____