BELLEVUE COLLEGE

Health Sciences, Education and Wellness Institute
STUDENT INFORMATION RELEASE AUTHORIZATION FORM

Student Name:	**SID #:**
I understand that Bellevue College makes every effort to maintain information provided by me as confidential. From time to time, an agency or outside employer who is an integral part of my education at the college will require information from my file. In order to expedite that request and avoid any negative consequences to my success, this release authorization is required. My signature below authorizes Bellevue College's Nursing Assistant Certified _____ program to disclose the information in their file to any third party when it is required as part of my education. I understand that all records are to remain confidential and will be re-released by the third party without my authorization.	
Signature:	**Date:**