WESTERN KENTUCKY UNIVERSITY
Associate of Science in Nursing (LPN to ASN) Program
Spring 2024

Consent Form for Release of Medical Information

I_____ give the Associate of Science in Nursing (LPN to ASN) Program at Western Kentucky University permission to release my medical records and/or Social Security number to any clinical/practicum site to fulfill my clinical obligations. I understand the consent for release of medical information is valid until graduation from the LPN to ASN Program.

My admission into the program is contingent upon this form being signed, notarized, and returned to the LPN to ASN Program office no later than Monday, Sept 25th, 2023.

Please send this back to us **via email** to asnnursing@wku.edu. Please do **NOT** mail this form back to us. Even with the Notary Seal, the form can be emailed.

_____
Student's Signature

_____
Student's Printed Name

_____
Social Security Number

COMMONWEALTH OF KENTUCKY/ or_____)
COUNTY OF)

Personally appeared before me, the undersigned, a Notary Public in and for said County and State, the within named_____, with whom I am personally acquainted or proved to me on the basis of satisfactory evidence, and who upon oath acknowledged that he/she the within named instrument for the purposes therein contained, this the _____ day of _____, 20___.

_____
NOTARY PUBLIC STATE AT LARGE

My Commission Expires: