

RELEASE FORM

COLLEGE OF DUPAGE HEALTH SERVICES
425 FAWELL BLVD., GLEN ELLYN, ILLINOIS 60137
630-942-2154 tel / 630-942-2071 fax

I, _____ shall indemnify, protect and save and keep harmless, College of DuPage, its agents, servants, successors and assigns from and against all losses, damages, injuries, claims and demands and expenses, including legal expenses, arising out of my participation in educational experiences, including hospital/clinical practice.

I, _____ shall assume all such losses, damages, injuries, claims demands and expenses of the settlement or in the defense of any suit or suits or legal proceedings and shall pay all judgments entered in any such suit or other legal proceedings. The indemnities and assumptions of liabilities and obligations herein provided for shall continue in full force and effect not withstanding during the College of DuPage school year whether by expiration of time, by operation of law or otherwise.

Signature _____ Date _____

Witness _____

Authorization for Release of Information

I, _____ hereby, give my consent to the College of DuPage Health Center to release my medical records to my clinical site.

Signature _____ Date _____

SS# _____