**CONSENT FOR RELEASE OF INFORMATION**
**HOLD HARMLESS AGREEMENT**
**FOR STUDENTS**

**CRIMINAL HISTORY RECORD INFORMATION**

By this Consent for Release of Information and Hold Harmless Agreement (AGREEMENT), **I REQUEST AND AUTHORIZE** Texas Tech University Health Sciences Center El Paso (TTUHSCEP or University) to obtain, and/or receive from a third party source (VENDOR) selected by TTUHSCEP, criminal history record information (INFORMATION) for the purpose of conducting a criminal background check (CBC). **I UNDERSTAND AND AGREE** that the cost of conducting the CBC shall be my responsibility. I further **UNDERSTAND** that I am required to self-disclose any past criminal activity, if applicable, and further **UNDERSTAND** that should I be charged with a crime after beginning school, I **SHALL** report to the Dean or his/her designee such INFORMATION no later than five (5) business days following such charge. The purpose of this INFORMATION is to determine the existence of, investigate any past criminal activity, and evaluate such INFORMATION, if any, which may be used to determine eligibility, character, or fitness to matriculate or enroll at TTUHSC, or pursue health-related clinical training provided by or through TTUHSCEP. I **UNDERSTAND** that I may challenge the accuracy of INFORMATION disclosed by VENDOR and can obtain information on the procedure to challenge such INFORMATION in the Office of the Registrar. In addition, if I have challenged the VENDOR's INFORMATION, which is determined to be accurate, and adverse action is subsequently taken against me by TTUHSCEP, I may appeal such decision to an ad hoc committee constituted by the Dean. **I UNDERSTAND** that information in this report which reflects character and fitness to pursue training in healthcare constitutes credit information as defined under the Fair Credit Reporting Act.[1] **I ACKNOWLEDGE** that this information will be obtained prior to matriculation/enrollment in some cases and, otherwise, prior to participating in patient interactions or clinical activities conducted at TTUHSCEP and/or other affiliated healthcare facilities. Furthermore, **I UNDERSTAND** additional CBCs may also be conducted on an as needed basis, the cost of which is also my responsibility. **I FURTHER UNDERSTAND AND AGREE** that any INFORMATION obtained by TTUHSCEP or VENDOR will be released to the applicable TTUHSCEP school(s) and/or affiliated healthcare facility(ies) (ENTITIES) for such time that I am enrolled as a TTUHSCEP student in order for ENTITIES to determine whether I may participate in patient interactions or clinical programs. Such INFORMATION will be disposed of thereafter in accordance with the Fair and Accurate Credit Transaction Act.[2] **I UNDERSTAND** that the ENTITIES are permitted to communicate with each other regarding the content of the INFORMATION provided by VENDOR. **I UNDERSTAND** that this AGREEMENT is voluntary and that I may in writing revoke it at any time by contacting the TTUHSCEP Office of the Registrar, except to the extent that action has been taken in reliance on this AGREEMENT.

**I UNDERSTAND AND AGREE that I will be required to cooperate with TTUHSCEP and/or VENDOR in providing truthful and timely information and further UNDERSTAND that should I revoke this AGREEMENT, fail to cooperate or provide truthful information, such action may result in my inability to matriculate/enroll and/or participate in patient interactions or clinical activities, resulting in the withdrawal of admission or immediate dismissal from TTUHSCEP. I further UNDERSTAND that the information obtained will be used for the express purpose of determining eligibility and fitness, or having the requisite character or fitness, for participating in those various programs to which I seek approval.**

[1]FCRA, 15 U.S.C. Section 1681b.
[2]FACTA, C.F. R. Section 682.1 *et seq.*

I **UNDERSTAND** that the ENTITIES must use the INFORMATION solely for its intended purpose, as outlined above, and that the ENTITIES cannot warrant or guarantee the control or use of this INFORMATION should it be acquired by someone other than ENTITIES. Accordingly, I AGREE that TTUHSCEP and the affiliated healthcare facilities shall not be held responsible or liable for damages of whatever kind which may result from the improper release or dissemination of the INFORMATION referenced hereinabove. **I EXPRESSLY RELEASE AND AGREE TO HOLD HARMLESS** TTUHSCEP, its officers, directors, board of regents (both individually and collectively), agents, employees, and personnel acting on behalf of UNIVERSITY, from any and all liability including, but not limited to, negligence, associated with the release of the INFORMATION which it provides to its agents, employees and personnel or an affiliated healthcare facility, its agents, employees and personnel. Criminal History Record Information is confidential and shall be protected from disclosure to the greatest extent provided by law.

**I REPRESENT** that I have read this document (or have had it read to me*) and understand its implications. My true and complete legal name, including all other previous names by which I have been known, is as indicated below, and all INFORMATION included herein is true and correct.

***PLEASE PRINT LEGIBLY***

_____

*Last Name* *First Name* *Middle Name* *Maiden Name*

_____

*Other Names by Which I Am/Have Been Known*

_____

*Address(es) (**Current and Prior**, Including Cities, Counties and Countries of All Known Residences)*

_____

_____ _____

*Date of Birth* *Social Security Number*

_____

*List prior criminal history record information, if applicable, giving relevant dates, location, circumstances, etc. Please use a separate sheet of paper, if needed. If not applicable, indicate with N/A.*

_____ _____

**SIGNED** *(Student)* *Date*

_____ _____

**SIGNED** *(Witness or Translator*)* *Date*

**In the event a Student, Trainee, Resident or Fellow is unable to sign, a Witness/Translator should sign on that individual's behalf, indicating that the individual to whom this AGREEMENT applies has been informed and agrees.*