VERA Z. DWYER COLLEGE
OF HEALTH SCIENCES
INDIANA UNIVERSITY SOUTH BEND
School of Nursing

Authorization for Release of Documentation

I, _____, authorize Indiana
(print name)
University South Bend School of Nursing to release documentation of my TB screening, CPR, criminal history, urine drug screen, and immunization records to our affiliated clinical sites. I release IUSB School of Nursing and all individuals connected therewith from any and all liability from damage that may be incurred in furnishing such information. I also give IUSB School of Nursing permission to discuss my records with a clinical site.

_____
Date

_____
Signature