



**Saint Louis University School of Nursing
Authorization to Release Information**

I am scheduled for clinical experiences outside of Saint Louis University. The institutions where I am scheduled to complete my clinical rotations may require that Saint Louis University release my phone number, immunization and PPD records, the results of my criminal background check and drug screen, and documentation of my HIPPA and OSHA education attendance before I begin clinical training.

Therefore, I authorize Saint Louis University School of Nursing to release my phone number, immunization and PPD records, background check, and drug screen results, and attendance records for HIPPA and OSHA education to the institutions where I am scheduled for clinical training.

This permission extends for the duration of my enrollment as a student at Saint Louis University School of Nursing. I understand that I may withdraw this permission by notifying the Director of the Baccalaureate, Master's, and DNP program in writing. However, withdrawal of this authorization will not affect information that has already been released.

I understand that withdrawing my permission may prevent my placement at outside clinical sites and prevent my School of Nursing program completion.

I understand that the information disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient institutions and may no longer be protected by federal regulations.

Signature	Date
Printed Name	Student Banner ID

Program Option (BSN, MSN, PM, DNP, PhD)

Students must upload this signed form to CastleBranch.