Consent to Release Records

I, (print name clearly)_____, (UW ID No. _____) hereby give my consent to the University of Washington, School of Nursing to release any and all of the following information to the North Puget Sound Consortium members, clinical agencies outside of the consortium that are part of my clinical experiences, and training sites for my education at the University of Washington, School of Nursing.

I, (print name clearly)_____, (UW ID No._____) hereby give my consent to the Health Sciences Immunization Program (HSIP) to release my immunization records including but not limited to immunization dates and results, lab results, and my TB Screening results (which may include, lab, TB skin tests and/or chest x-ray results) to the UW School of Nursing to share with the North Puget Sound Consortium members, clinical agencies outside of the consortium that are part of my clinical experiences, and training sites for my education at the University of Washington, School of Nursing.

- Name, local address, e-mail address, phone number
- Birth date
- UW Student Number
- Criminal Background Check
- Immunization records w. dates & results
- TB Screening Test results
- Lab results
- Verification of comprehensive health insurance (if applicable)
- Last 4-digits of social security number
- CPR
- Blood borne pathogen training dates
- Hazard Management training dates
- HIPAA training dates
- Health Care License (RN)

I understand that this information is used solely for the necessary operations at the clinical agencies and training sites, including but not limited to credentialing, computer access, medication systems, building access during my clinical rotation.

_____

Signature of Student Date

Approved July 2012/AG/AS

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