COLLEGE OF
Saint Benedict Saint John's
UNIVERSITY

Authorization to Release

Tuberculin Skin Test – Vaccinations – Urine Drug Screen

Patient Name: _____ Date of Birth: _____ / _____ /_____

I authorize CSB/SJU Health Services to disclose the following records: (choose all that apply)

☐ Immunizations ☐ Tuberculin Skin Test ☐ Urine Drug Screen

To the following Entity: _____

Address and/or Fax: _____

PATIENT SIGNATURE: _____ **DATE:** _____

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