



**TRINITY COLLEGE OF
NURSING & HEALTH SCIENCES**
IOWA HEALTH SYSTEM

Release of Information Form

Name (Print): _____ SSN: _____ / _____ / _____

I authorize all educational institutions contracted with Trinity College of Nursing & Health Sciences to share all information concerning my academic records and billing statements, understanding that this information will only be used to update and maintain my enrollment status.

Signature: _____ Date: _____

- Nursing
- Radiography
- Respiratory Care