

## **Credentialing Release of Information Authorization**

In order for	(facility name) to access and verify my educational	
background, professional qualification	ns and suitability for appointment, I	hereby authorize
	(facility name) to make inquiries and	consult with the HIV/AIDS
Nursing Certification Board, who may	have information bearing on my pro	ofessional qualifications and
competence to carry out the privilege	es I have requested. I consent to the	release of information and
related documents to	(facility name).	
I release from liability all those who p	rovide information to	(facility name) in
good faith and without malice in resp		,
Printed Name	Date	
Signature		