

AUTHORIZATION TO RELEASE PROTECTED HEALTH AND DIETARY INFORMATION

Off-Campus Short-Term Programs

For Release of Health and Dietary Information: I hereby authorize and request the College of St. Benedict and St. John's University through the Office for Education Abroad (OEA) and Staff (the "Program") to copy and release health and dietary information prepared and submitted by me to the Program using the on-line form provided for that purpose. The Program may copy and release my health and dietary information to persons, institutions, or health care providers that have a reasonable need to know the information. Furthermore, it is my understanding that the following named Program Director shall serve as the caretaker of my health and dietary information and the decision-maker in respect to the release of such information during my participation in the Program.

For Collection of Health and Dietary Information: I hereby authorize and request the Program, the Program Director, and others entrusted with my health and dietary information to advise providers, professionals, entities or other persons to seek additional information when necessary from health care providers that I have listed on the attached Health and Dietary Information Form. In addition, I hereby authorize those providers that I have listed to release all health information requested without exception or as otherwise limited in the following Restrictions and Limitations section of this Authorization.

Restrictions and Limitations: I understand that my health and dietary information may include sensitive information such as that related to the treatment of drug or alcohol abuse, mental health conditions, or HIV/AIDS, STD, etc. I further understand that I may limit the type and amount of information to be released or collected by a signed and dated writing that communicates specific restrictions to the Program Director or as I now limit by the following description:

Time Period Limitation: This Authorization relates to the health and dietary information that I have provided to the Program prior to my signature on this Authorization and also includes records prepared or collected by the Program after the date of signature on this Authorization for a period of "one year".

Signature: This authorization will remain in effect for a period of one year from the date of signature. However, I may revoke this authorization at any time, through a writing that is signed, dated, and effectively presented to the Program for processing. I understand that such revocation does not apply to any information already released or collected, in good faith, by the Program. I also understand that a facsimile or photocopy of this authorization shall be valid as the original signed and dated document.

****SIGNATURE AND CONSENT IS GRANTED THROUGH THE
SHORT-TERM OFF-CAMPUS PROGRAM WAIVER AND RELEASE FORM****