STAY SAFE MN

COLLEGE OF Saint Benedict Saint John's UNIVERSITY

Authorization for Disclosure of Protected Health Information

Patient Information

Patient/Student name: _____

Patient/Student date of birth:_____

Phone number: _____

Release Information

Release Information From:
(*name of patient/student*)

_____

Release Information To:
Lori Klapperich-Student COVID-19 Coordinator
Erin Ross and Scott Bierscheid-Head athletic trainers (only if athlete)

Brother Dan Morgan and Christy Brown-Directors of Res Life (if living on campus)

Purpose of Release

This authorization will allow College of Saint Benedict Health Services to work with above mentioned to discuss and coordinate my care for COVID-19 testing and recovery.

Information to be Released

Medical Information

Any symptoms, testing and lab test results relating to COVID-19 screening.

Service Dates

Any visits from the date I sign this form and one year forward.

Expiration/Effective Dates

This consent will expire one year from the date I sign it. This authorization applies to any symptoms, testing and lab tests results related to COVID-19 screening after the date of my signature.

I may revoke this consent at any time by sending written notice to the CSB Health Services. I understand this consent is voluntary and that I may refuse to sign. My refusal to sign will not affect my ability to obtain treatment or seek healthcare.

Signature: _____

Date signed (required): _____

Time signed (required): _____

Relationship, if not patient: _____

Please fax completed form to CSB Health Services at 320-363-6396 or email to tlongfellow@csbsju.edu