MINNESOTA DEPARTMENT OF HEALTH

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 From:

HEALTH SERVICES
College of Saint Benedict/
Saint John's University

### Release Information To:

**Athlete, release to:**
Erin Ross, Scott Bierscheid, Nicci Malecha
CSB|SJU Athletics

## Purpose of Release

This authorization will allow College of Saint Benedict/Saint John's University 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 test 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|SJU 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: _____

# Fax or email completed form to CSB/SJU Health Services at 320-363-6396 or tlongfellow@csbsju.edu

MINNESOTA

Minnesota Department of Health | health.mn.gov | 651-201-5000
625 Robert Street North PO Box 64975, St. Paul, MN 55164-0975

Contact health.communications@state.mn.us to request an alternate format. 07/26/2021