HOLLINS UNIVERSITY
INTERNATIONAL PROGRAMS

Health Information Release

I, _____,
(print name)

hereby give my permission for Health and Counseling Services at Hollins University to release my Hollins University health records to the Director of International Programs and/or the faculty leader of the Short Term course in which I have enrolled. I understand that any information provided to these individuals will not affect my acceptance to a Hollins University study abroad program or travel/study course and will be shared only when necessary for my own health and safety or to be sure arrangements can be made to meet my needs.

_____ _____
Signature Date

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