



CATHOLIC
DIOCESE
OF WICHITA

CATHOLIC DIOCESE OF WICHITA
424 NORTH BROADWAY · WICHITA, KANSAS 67202

OFFICE OF VOCATIONS
PHONE: (316) 269-3900 · FAX: (316) 269-3902

AUTHORIZATION AND RELEASE FORM

I understand that consideration for acceptance into the seminarian formation program is contingent upon the results of the following: Reference Check, Background Check, HIV Test, Medical Exam, Psychological Evaluation, and Transcripts from Institutions of Education. I authorize the Catholic Diocese of Wichita to investigate all statements made on this application and to discuss the results of its investigation with those responsible for determining my eligibility for acceptance.

I authorize the Catholic Diocese of Wichita, its employees or agents to release necessary emergency contact information, including medical information that is deemed necessary, to places of employment, or places I reside during my tenure as a seminarian.

I authorize the Catholic Diocese of Wichita to release the results of my psychological evaluation, my medical records, HIV test, reference check, background check, and/or education transcript(s) to the specific seminary where I attend school. I understand the information is kept in a secure place and will be used to aide me in my vocational discernment and personal growth.

I authorize the Catholic Diocese of Wichita, its employees or agents to contact my former employers, any listed references, and any other individuals who can verify information about me. I give my permission for all contacted individuals and former employers to respond to questions pertaining to information on this application, as well as to questions about my character. Further, I release from liability all former employers or other contacted individuals for providing information to employees or agents of the Catholic Diocese of Wichita.

I, the undersigned, have read the above and authorize the staff of the Catholic Diocese of Wichita to disclose/release such information as herein contained. I understand that this consent may be withdrawn by me in writing at any time except to the extent that action has been taken in reliance upon it. This consent shall expire when I am no longer an applicant or candidate for seminary for the Diocese of Wichita or upon completion of my formation.

I understand that any disclosure/release of medical records is bound by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") 45 C.F.R. Pts. 160 & 164; and that redisclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.

I acknowledge that no material information about me relative to this application has been withheld, and that the information I have supplied is correct to the best of my knowledge. I understand that any deliberate falsification, misrepresentation or omission of fact may be grounds for rejection of my application for admission, or for removal from the seminary if already admitted.

Signature of Applicant

Legal Guardian

Print Name

Witness

Date