Student ID# _____

Authorization to Release/Exchange/Obtain Confidential Information

I, _____ hereby authorize the Office for Access and Accommodations (OAA), Southern Illinois University Carbondale to:

exchange with release to obtain from

[student must initial appropriate space(s) to indicate if information is to be exchanged, released, or obtained]

_____ _____

_____ _____

Name of Health Care Facility, Physician, School, Agency, Etc. *Address*

All information contained in the clinical file of _____ _____, relating to

(Student) *(Birth Date)*

services provided to the above-named student from _____ to _____ for the purpose(s) of:

(Date) *(Date)*

(1) _____

(2) _____

(e.g., disclose disability limitations/impairment in major life activities, plan accommodations, assist with use of accommodations, transfer of accommodations, disclosure to credentialing agency, disclosure to other agencies for services, release to student, etc.)

The type of information to be used or disclosed is as follows:

NOTE: The student must initial each checked area and provide an expiration date for this to be a valid authorization.

Type of Information	Authorization EXPIRES month/day/year	Initials
Psychological assessment report	_____	_____
Vision/Hearing screening	_____	_____
IEP/504Plan	_____	_____
Medical records	_____	_____
Treatment summary	_____	_____
Academic records	_____	_____
Other (please specify) _____	_____	_____

Special Instructions: (e.g., appointment date or pick up date/time/location):

_____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the OAA. I understand that the revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of any health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact SIU's privacy officer.

SIGNED _____ DATE _____

(Student or authorized representative – Student under 18 years of age, Parent or Legal Guardian)

If you are not the Student, please specify your relationship to the Student: _____

WITNESS _____ DATE _____

By signing above Witness attests that the Student/Authorized Representative signing above personally appeared before Witness and proved to Witness through satisfactory evidence to be the person whose name and signature is subscribed as Client/Authorized Representative herein or was personally known to Witness to be such person.

Last Modified: May 10, 2024 10:26 AM