Disability Services | 610-568-1499 Phone | 484-335-4486 Fax | disability.services@alvernia.edu

Authorization for Release of Information

(*Please PRINT*)

Date of Birth: _____ Last 4 of SS#: ____ ____ ____ ____

Name: _____ Student ID: _____

(LAST) (FIRST) (M.I.)

(*Check all that apply*)

☐ I authorize the Disability Services Office to release information to:

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone (include area code)

_____
Fax (include area code)

☐ I authorize the Disability Services Office to obtain information from:

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone (include area code)

_____
Fax (include area code)

TYPE OF INFORMATION AUTHORIZED (*Check all that apply*):

☐ Assessments/Evaluations ☐ Medical Records ☐ Progress Notes
☐ Discharge Summary ☐ Treatment Plans/Treatment Summary ☐ Diagnostic Impression
☐ Lab Test Results ☐ 504 Plan ☐ ER and IEP
☐ Other (*please specify*): _____

☐ I give permission to Disability Services to release confidential information about my disability to my advisor, instructors and other appropriate campus personnel (i.e. health and wellness, safety) on a need-to-know basis.

MY AUTHORIZATION WILL EXPIRE (*Check one*):

☐ When I am no longer receiving services from the DSO.
☐ One year from this date.
☐ Other (*please specify*): _____

AUTHORIZATION: I certify that this request was made voluntarily and that I may revoke this authorization at any time by notifying the DSO in writing. If the entity authorized to receive this information is not a healthcare or health plan provider, I understand that the released information may not be protected by federal privacy regulations.

_____ _____
Signature of Student Date

_____ _____
Signature of Witness Date