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**LIMITED RELEASE OF INFORMATION**

STUDENT NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize AUSTIN COLLEGE ACADEMIC SKILLS CENTER to RECEIVE medical and/or mental health information and/or records regarding diagnosis and treatment, for the College to determine whether student qualifies for an accommodation request.

RELEASE TO/RECEIVE FROM \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(EX: REFERRING PHYSICIAN, MENTAL HEALTH PROVIDER, DIAGNOSTICIAN, RELATIVE, ATTORNEY, ETC.)

The information may be provided: 󠄀 󠄀 by phone 󠄀 by fax 󠄀󠄀 by mail 󠄀 by email

󠄀 *I understand that electronic mail (email) is not confidential and can be intercepted and read by other people.*

Information to be provided: 󠄀󠄀 Attendance/Dates of service 󠄀󠄀 Diagnosis 󠄀󠄀 Treatment plan/goals

󠄀 Treatment Summary 󠄀 Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any medical and/or mental health information that you do not wish to be released?  Yes  No

If so, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* I understand that I have a right to receive a copy of this authorization.
* I understand that any cancellation, modification, or revocation of this authorization must be in writing.
* I understand that I have the right to revoke this authorization at any time unless Austin College Student Life has taken action in reliance upon it.
* I understand that it is my responsibility to confirm receipt by Austin College Academic Skills Center of any cancellation, modification, or revocation.
* I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Texas law may protect such information. In consideration of this consent, I hereby release the source of the records from all liability arising there-from.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CONSENT to the release of information \_\_\_\_\_\_\_\_\_\_\_

(Signature of student) (Date)

EFFECTIVE TIME PERIOD. This authorization is valid for 1 year from the date signed unless another date is specified below.

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| --- |
| **Only complete this box if you wish to withdraw permission to release information.**  I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, wish to withdraw my consent to release  information on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.    \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  (Signature of student) (Date) |