AUSTIN COLLEGE | Academic Skills Center

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: NAME OF REFERRING PHYSICIAN, MENTAL HEALTH PROVIDER, DIAGNOSTICIAN)

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 Academic Skills Center 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.

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)