Authorization to Disclose Health Care Information

Luther College Disability Services
Preus Library, Suite 108
700 College Drive, Decorah, IA 52101
Phone 563.387.1270 Fax 563.387.1411

Patient Information:

Patient Name _____ Student I.D.# _____

Former Name (if any) _____ Birth Date _____

Address _____

Phone # _____ Cell Phone _____ E-mail _____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release Information From:

_____

_____

_____

Send My Information To:

Luther College Attn: Disability Services

Preus Library, Suite 108; 700 College Drive

Decorah, IA 52101

Medical Information Requested to be sent:

- ❑ Complete Records
- ❑ Diagnostic Report(s)
- ❑ Other Medical History discussing disability
- ❑ Medical History
- ❑ Progress Report
- ❑ School Records
- ❑ Psychological/Psychiatric Evaluation
- ❑ Testing Results/Evaluations
- ❑ Treatment Plans

Reason for Release:

- ❑ To determine eligibility for services
- ❑ Coordination of services
- ❑ Other _____
- ❑ Provider change
- ❑ Renew Accommodations
- ❑ Talk with Parent/Guardian

I UNDERSTAND THAT:

- This authorization will automatically expire **one year** from the date of my signature on or _____.
- This authorization may be revoked at any time by notifying Luther College Disability Services in writing except to the extent that action has been taken in reliance of it.
- I can request an accounting of disclosed information by writing to Disability Services.
- My refusal to sign, or revocation of, this authorization will not affect my ability to obtain services from Luther College Disability Services.
- The information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.

_____ _____

Signature of patient or legal guardian (patients over 18 must sign release) Date

_____ _____

Relationship and authority, if not the Patient Witness