AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

JAG ID: ___________________________

INSTRUCTIONS

Fill in the appropriate information in each applicable section. Sign and date the form. A separate authorization must be completed for each request.

Student Full Name: ____
Last First Initial

Date of Birth: ______________________________ Telephone: ( ) ____________________

Address: Street: ____

City: ______________________________ State: ____________ Zip: _______________

I, ______________________________, hereby authorize the following party to use, disclose, or verbally discuss with the University of South Alabama the health information indicated below and contained in my medical records, which includes information that may be stored in paper and/or electronic format:

Provider: ____

Address: ____ Email: ____

Phone: ____ Fax: ____

for the purpose of determining reasonable accommodations at the University of South Alabama. Such information includes, but is not limited to, records on general medical care; physical exam results and diagnoses; treatment records; communicable diseases or infections; demographic information; and treatment received at other health care providers.

I further consent to the disclosure of the following specific types of information (please initial):

_______ Information pertaining to drug or alcohol abuse, diagnosis, or treatment.
_______ HIV/AIDS testing information.
_______ Genetic testing information.
_______ Information pertaining to mental health diagnosis or treatment.
_______ Information pertaining to psychotherapy notes.
_______ Entire Record

Any such records to be provided to the University of South Alabama shall be directed to:

USA Office of Student Disability Services
320 Student Center Circle
Educational Services Building, Ste. 19
Mobile, AL 36688
disabilityservices@southalabama.edu

This authorization shall remain in effect until such time as I am no longer a student at the University of South Alabama or I provide written notice to the medical provider or the University of South Alabama of my desire to withdraw this authorization.

DISABILITY DOCUMENTATION REQUIREMENTS FOR PROVIDERS

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1. Clearly state the diagnosed disability or disabilities.
2. Documentation must be current (i.e., completed within the last three years for learning disorders, ADHD, or disabilities other than psychological disabilities and within the last three years for psychological disabilities). This requirement does not apply to physical or sensory disabilities of a permanent or unchanging nature.
3. Documentation must include the complete educational, developmental, and medical history relevant to the disability for which accommodations are being requested.
4. Include a list of all test instruments used in the evaluation report and relevant subtest scores used to document the stated disability. This requirement does not apply to physical or sensory disabilities of a permanent or unchanging nature.
5. Documentation must be typed on official letterhead and signed by an evaluator qualified to make the diagnosis. Include information about licensing, certification, and area of specialization.

STUDENT ACKNOWLEDGMENTS

1. I understand that I can revoke this authorization at any time by submitting written revocation to the provider. However, uses and disclosures permitted while the authorization was in effect cannot be taken back.
2. I understand and acknowledge that the provision of healthcare to me is not conditioned on my execution of this authorization.
3. I understand that information disclosed per this authorization may be subject to redisclosure by the receipt and no longer protected by the Health Insurance Portability and Accountability Act (HIPAA).

Student Signature: ____ Date: _______________________

If the student is a minor or unable to sign, please complete the following:

Name of Parent/Guardian: ____________________________________ Relationship to Student: ______________________

Signature of Parent/Guardian: ____________________________________ Date: _______________________