Idaho State University

Disability Services
921 South 8th Avenue, Stop 8121, Pocatello, Idaho 83209
Rendezvous Center Room 125

RELEASE OF PROTECTED HEALTH INFORMATION

Student/Employee: _____ Date of Birth:_____
Address: _____ Telephone: _____
Other names under which student/employee has received treatment: _____

Agency Named Below Has Permission to: (please checkmark all applicable permissions)
Send: ☐ Receive: ☐ Both: ☐

Person/Agency: _____
Contact Name: _____
Phone:_____ Fax: _____

ISU Disability Services Has Permission to: (please checkmark all applicable permissions)
Send: ☐ Receive: ☐ Both: ☐

Purpose of Disclosure: To be used by Idaho State University's Disability Services to verify individual's disability in order to determine appropriate academic or employment accommodations. Also may be used to release disability information from ISU to outside agency at student/employee's request.

Information to be Disclosed:

I hereby authorize use or disclosure of protected health information about me as described below:

☐ All pertinent medical and/or psychological information and testing results and reports including **specific diagnoses of disabilities and DSM-5 diagnoses** in my records.

☐ My health information relating to the following conditions: _____

☐ Other: _____

This request is valid for services during the following:

Approximate service date _____ to ☐ date: _____

☐ current, until expiration of this form.

Release Statement:

1. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it, and would then no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).
2. If information is disclosed from records protected by Federal confidentiality rules, the Federal rules prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted, in writing, by the person to whom it pertains.
3. I may revoke this authorization by notifying **Idaho State University's Disability Services** in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
4. I understand that this authorization is for the above stated purpose only and will not impact my healthcare benefits, treatments, payments, or enrollment.
5. I authorize ISU Disability Services to speak to my treating physician or health care provider directly in regards to any questions s/he may have with respect to my condition that relate to the performance of essential academic or employment duties and any accommodations that may be necessary.

Note: This authorization will expire one (1) year from date signed.

Signature: _____ Date: _____