Idaho State University

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

AUTHORIZATION TO DISCLOSE TO SECOND PARTY

Student/Employee: _____ Date of Birth:_____
Address: _____ Telephone: _____
Disability Services Coordinator: _____

Release Information to:

I, _____ (student/employee name), authorize Idaho State University's Disability Services to use and disclose my protected health information described below to:

Second Party Name: _____ Telephone: _____
Relationship to Student/Employee: _____

Extent of Authorization (select one):

☐ I authorize the release of my complete Disability Services record including information relating to academic/employment accommodations, medical and psychological information, testing results and reports including diagnoses of disorders and/or disabilities, treatment and disclosure of alcohol and drug abuse, and communicable diseases including HIV or AIDS.

☐ I authorize the release of my student/employee information relating to the following (fill in line below):

_____

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

This authorization for release of information covers the following time period:

Date: _____ to _____or ☐ All past, present, and future periods.

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.

Student/Employee Signature: _____ Date: _____
Second Party Signature: _____ Date: _____