Disability Services | 610-568-1499 Phone | 484-335-4486 Fax | disability.services@alvernia.edu

Authorization for Release of Information

(*Please PRINT*)

Date of Birth: _____ Last 4 of SS#: ____ ____ ____ ____

Name: _____ Student ID: _____

(LAST) (FIRST) (M.I.)

(*To be filled out only if student is transferring to another school*)

☐ I authorize the Disability Services Office to release information to:

_____
Name

_____
Address

_____
City, State, Zip Code

_____
Phone (include area code) Fax (include area code)

TYPE OF INFORMATION AUTHORIZED (*Check all that apply*):

☐ Assessments/Evaluations ☐ Medical Records ☐ Progress Notes
☐ 504 Plan ☐ ER and IEP ☐ Copy of Alvernia Accommodation Letter
☐ Other (*please specify*):_____

☐ I hereby grant permission to the Office of Disability Services to release confidential information about my disability to my advisor, instructors and other appropriate campus personnel (i.e. health and wellness, safety) on a need-to-know basis.

MY AUTHORIZATION WILL EXPIRE (*Check one*):

☐ When I am no longer receiving services from the DSO (graduation or withdraw from the university).
☐ One year from this date.
☐ Other (*please specify*): _____

AUTHORIZATION: I certify that this request was made voluntarily and that I may revoke this authorization at any time by notifying the DSO in writing. If the entity authorized to receive this information is not a healthcare or health plan provider, I understand that the released information may not be protected by federal privacy regulations.

_____ _____
Signature of Student Date

_____ _____
Signature of Witness Date

If completing this form electronically, please attach a scanned copy of a valid photo ID.