Confidential Authorization to Release Medical Information/Records

I, _____ _____ _____,
(full name) (date of birth) (Student ID#)
hereby authorize the release of medical information/records concerning me to the University of Houston Center for Students with DisABILITIES.

I further authorize all health care professionals who have treated me to discuss the care and treatment they provided to me with the professional staff of the University of Houston Center for Students with DisABILITIES, and waive any physician/patient privilege or confidentiality protection to which I may be entitled.

Due to my medical condition, I have requested certain course, classroom, and/or testing accommodations from the University of Houston. Therefore, the primary purpose of this authorization is to provide the requisite medical documentation of my medical condition in order to establish the appropriate course, classroom, and/or testing accommodations that I require.

I authorize the University of Houston Center for Students with DisABILITIES to disclose my information/records from the University of Houston Center for Students with DisABILITIES (which may include medical information/records provided in the application process to the University of Houston Center for Students with DisABILITIES) to the following other agencies, departments, and/or service providers to the extent consistent with above-stated purpose of obtaining certain course and/or testing accommodations:

(Please initial all that apply)

_____ appropriate UH faculty, staff and administrators as needed

_____ standardized testing agents (e.g., for the TASP, GRE, LSAT, etc.) as needed

_____ other institutions of higher learning as needed and specified below:

_____

_____ other off-campus professionals as needed and specified below:

_____

_____ other: _____

I also authorize the University of Houston Center for Students with DisABILITIES to disclose my information/records from the University of Houston Center for Students with DisABILITIES (which may include medical information/records provided in the application process to the University of Houston Center for Students with DisABILITIES) to the following persons:

(Please initial if applicable and list relationship with persons listed, such as, for example, your parents)

_____ _____

_____

I understand that all of the medical information that I have authorized for disclosure pursuant to this authorization shall be held strictly confidential and will not be released without my permission, except to the extent allowed and authorized herein. I release the University of Houston Center for Students with DisABILITIES, its directors, officers, administrators and employees from any and all legal responsibility or liability resulting from the disclosure of information/records that I have authorized to be disclosed.

I understand that this authorization is to remain in effect throughout my enrollment at the University of Houston. In the event I wish to revoke this authorization, I understand that such revocation shall be in writing and signed by me and shall be presented to the University of Houston Center for Students with DisABILITIES, and that such revocation shall not affect information/records disclosed prior to the date such revocation is presented. I further understand that I may not maintain an action against the University of Houston for any disclosures made by its agents in good faith reliance on this authorization if the University of Houston Center for Students with DisABILITIES did not have written notice that the authorization was revoked.

A copy of this authorization bearing my signature shall be valid as the original.

_____ _____

Student's Signature Date

_____ _____

Signature of Witness Date

If Student is under 18:

_____ _____

Signature of Parent Date

_____ _____

Signature of Parent Date

Note: Modification of this Form requires approval of OGC