**Disability Services**
P.O. Box 755590
Fairbanks, Alaska 99775-5590
907-474-5655
907-474-5688 fax
uaf-disability-services@alaska.edu

# AUTHORIZATION TO RELEASE PROTECTED INFORMATION

**Today's Date:** _____

**Student Name:** _____

**Phone Number:** _____ **Date of Birth:** _____ **UAF ID#:** _____

**Mailing Address:** _____

**I HEREBY AUTHORIZE THE DISCLOSURE AND USE OF MY INFORMATION:** [CHECK AS APPROPRIATE]

❑ **From** ❑ **To** ❑ **Both (Two-way)**
**UAF Disability Services**
1788 Yukon Drive
Fairbanks AK 99775
Phone: 907-474-5655
Fax: 907-474-5688

❑ **From** ❑ **To** ❑ **Both (Two-way)**
Name: _____
Street Address: _____
City, State, Zip: _____
_____
Phone: _____
Fax:_____

**DATES OF RECORDS/INFORMATION TO BE RELEASED** From: _____ To: _____ or ❑ All

**TYPES OF RECORDS/INFORMATION** [Check as appropriate]

❑ All medical records ❑ Disability Record(s) ❑ Psychological testing reports

❑ Diagnostic test reports ❑ Other (please specify):_____

Counseling visit notes (psychotherapy notes-to be released *after consult with counselor*):_____

If our records include records or information from another health care provider or entity, that information:
[Check one] ❑ should or ❑ should not be released under this Authorization.

**METHOD OF DISCLOSURE (check all that apply:** ❑ Mail ❑ Fax ❑ In person ❑ Verbal

**PURPOSE OF DISCLOSURE (optional):**

❑ Personal Use ❑ Disability Services Accommodation Request ❑ Legal ❑ Parent/Guardian ❑ Other

**EXPIRATION OF AUTHORIZATION**

This authorization will be in effect for **one year** unless otherwise noted here: _____

**Re-disclosure:** I understand that when the information is disclosed pursuant to this Authorization to someone who is not required to comply with the federal or state privacy protection requirements, it may be subject to re-disclosure by the recipient and may no longer be protected.
**Revocation:** I understand that I may revoke this Authorization at any time by writing to the address above. A request to revoke my authorization will not apply to the extent that Disability Services has taken action in reliance upon this authorization.

_____ _____ _____
Signature of student or other authorized person | Date | Printed name of other authorized person (if used)

**The Disability Services reserves the right to authenticate patient signature on forms received by fax or mail prior to the release of requested information.**

***FOR INTERNAL OFFICE USE ONLY***

Records released as instructed: By_____ Date _____