IOWA STATE UNIVERSITY
OF SCIENCE AND TECHNOLOGY

Student Disability Resources
Dean of Students Office
1076 Student Services Building
2505 Union Drive
Ames, Iowa 50011-2030
515 294-7220
FAX 515 294-2397

Limited Authorization to Disclose Health Care Information

Release of Medical Information to Coordinate Student Accommodations with ISU's Student Disability Resources

Patient Information:

Patient Name:	
Current Address (City, State, Zip):	
University ID#:	Date of Birth (MM/DD/YYYY):
Phone #:	Email Address:

I hereby authorize the disclosure of my health care information to Student Disability Resources of ISU from:

Send/Release To: Student Disability Resources	**Send/Release From:**
Address: 1076 Student Services Building	**Address**:
Ames, IA 50011-2222	
Phone: 515-294-7220 **Fax**: 515-294-2397	**Phone**: **Fax**:
Email: disabilityresources@iastate.edu	**Email**:

Reason for Release/Purpose of Disclosure:

Disability Accommodations: Assist in the interactive process between Student Disability Resources team and the patient's health care providers regarding academic &/or housing disability accommodations at Iowa State University.
Information Patient wants shared with Student Disability Resources (including records and follow-up conversations, as needed):
☐ IQ test result ☐ Educational test results ☐ Disability documentation ☐ Diagnostic statement
☐ Treatment history ☐ Medical test results ☐ Mental Health information ☐ Substance abuse information
☐ Other (specify):_____

Additional Consent: To be included in this release of records, **the patient must initial below** the specific information the healthcare provider may disclose for the following types highly sensitive medical records (if applicable):

Substance Abuse_____ Mental Health_____ HIV/AIDS_____ Sexual Assault Exam Information_____

Further, I agree and understand that:

1. This Authorization may be revoked at any time by notifying my provider in writing, except to the extent that action has been taken to comply with it.
2. I can request an accounting of disclosed information by contacting my provider at the address provided above.
3. My refusal to sign, or revocation of, this Authorization will not affect my ability to obtain health care services from my provider.
4. Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.
5. This Authorization will expire on _____. If no date provided, this Authorization will automatically expire one year from the date of my signature below.

Patient's Printed Name	Today's Date (MM/DD/YYYY)
Patient's Date of Birth (MM/DD/YYYY)	Patient's University ID#
Signature of Patient (or Legal Representative, if applicable)	If applicable, Legal Representative's Printed Name and Relation to Patient (e.g., Mother, Father, Guardian, etc.)

SDR Staff initials_____ Date Received by SDR:_____