Metropolitan State University

Release of Information to the Center for Accessibility Resources

I authorize (Person's name) ____

From (site and fax #) ____

To release to and/or discuss with the Center for Accessibility Resources the following information:

- Diagnosis of medical, mental health, or learning condition(s) that may be disabling
- How the condition(s) may affect me in an academic or employment setting
- (Optional) Recommendations for academic or employment accommodations

Send information to: ____

(Name) (Telephone) (Fax)

Center for Accessibilty Resources, Metropolitan State University

700 East Seventh Street, Saint Paul, Minnesota 55106-5000

Purpose for which information will be used:

To assist Metropolitan State University in determining whether I have a disability as defined by the ADA, and what reasonable accommodations may be appropriate.

My Identification:

Name ____

(First) (Middle) (Last)

Address ____

(Number & Street)

____

(City) (State) (Zip)

Date of Birth ____________________________ Telephone _________________________________

Dates of Services/Treatment (starting) _________________________ to ____________________

- I accept responsibility for any use made of the information as a result of this authorization.
- I understand that this authorization has no expiration date and that I may revoke it in a written request (or email) to the Center for Accessibility Resources at any time. I also understand the revocation will not apply to information released under this release prior to the Center for Accessibility Resources receiving any revocation.
- I understand that my health care provider's treatment is not conditional on signing this authorization.
- I understand that if I do not authorize the Center for Accessibility Resources to obtain the information requested in this release, the Center for Accessibility Resources may be unable to provide the services I am requesting.
- I understand that I am entitled to a copy of this authorization.
- I have been informed and understand that the information released by my provider to the Center for Accessibility Resources in accordance with this authorization may be redisclosed by the Center for Accessibility Resources and no longer protected by HIPPA. I am also aware that any information disclosed to the Center for Accessibility Resources is subject to other state and federal privacy laws.
- This authorization encompasses all records pertaining to my condition, including third party records created by other individuals or organizations.

Signature ____ **Date** _____________________________

If under 18 years of age,
Signature of Parent/Guardian ____________________________ **Date** ____________________________