Center for Disability Resources

PERMISSION TO DISCLOSE RECORDS
(HIPPA-COMPLIANT)

I, ______________________________________, hereby authorize the following
(Student Name)
individuals and/or organizations to disclose all records in their possession regarding me to the Center for Disability Resources (CDR) at Illinois Institute of Technology, 3424 S. State St., Room 1C3-2, Chicago, IL 60616 (phone) 312.567.5744 and for the CDR to release information it has to said individuals and/or organizations:

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____
(Provider's Information)

This authorization allows the above individuals and/or organizations to copy and send records to the CDR and allows representatives of the CDR to inspect the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the CDR staff.

This authorization encompasses ***all*** records pertaining to my condition, including "third party records" created by any other individuals or organizations.

Pursuant to HIPAA, the following are specified as part of this authorization:

a. The purpose of disclosure is to assist Illinois Institute of Technology in determining whether I have a disability as defined by the Americans with Disabilities Act and what accommodations may be appropriate.

b. This authorization expires one year after the date it is signed.

c. I understand that I may revoke this authorization at any time by providing written notification to Illinois Institute of Technology or the individuals and

organizations listed above, except to the extent that this authorization has already been relied upon.

d. I have been informed that the individuals and organizations listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.

e. I have been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. I am also aware that any information disclosed to Illinois Institute of Technology is subject to other state and federal privacy laws.

____ Date: ________________

Student Signature

____ Date: ________________

Parent/Guardian Signature
(If Student is Under Age 18)

Send Form To:

IIT Center for Disability Resources

3424 S. State St., Room 1C3-2

Chicago, Illinois 60616

disabilities@iit.edu