Authorization to Disclose Health Care Information

Luther College Accessibility Services
Preus Library, Suite 108
700 College Drive, Decorah, IA 52101

Phone: 563.387.1270 Fax: 563.387.1411

Patient Information:

Patient Name: _____

Former Name (if any): _____

Address: _____

Phone #: _____

Student Luther ID: _____

Birth Date: _____

Luther Email: _____

I HEREBY AUTHORIZE THE DISCLOSURE OF MY HEALTH CARE INFORMATION AS INDICATED:

Release Information From:
(Please list provider name, medical location, and address below)

_____

_____

_____

Send My Information To:

Luther College: Attn: Accessibility Services

Preus Library, Suite 108, 700 College Drive

Decorah, IA 52101

Medical Information Requested to be sent:

- ☐ Diagnostic Report(s)
- ☐ Medical Documentation discussing Disability
- ☐ Psychological/Psychiatric Evaluation
- ☐ Treatment Plans

Reason for Release:

- ☐ To determine eligibility for services
- ☐ To renew accommodations
- ☐ To determine coordination of services

I UNDERSTAND THAT:

- This authorization will automatically expire **one year** from the date of my signature or on _____.
- This authorization may be revoked at any time by notifying Luther College Accessibility Services in writing, except to the extent that action has been taken in reliance of it (healthcare information received).
- I can request an accounting of disclosed information by writing to Accessibility Services.
- My refusal to sign, or revocation of this authorization, may affect my ability to obtain services from Luther College Accessibility Services.
- The information may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy rules.

_____ _____

Signature of patient or legal guardian (only if under 18) **Date**

_____ _____

Relationship and authority, if not the Patient **Witness**