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:

_____

_____

_____

_____
(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*

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