Student Disability Services
CCSU
Central Connecticut State University

Authorization for Release/Disclosure of Personal Information

I hereby authorize Central Connecticut State University's Student Disability Services to release/ disclose my individually identifiable information as described here to the person/organization named below. I understand that this authorization is voluntary and that it may include information relating to AIDS/HIV infection, behavioral health services, psychiatric care and treatment for alcohol and/or drug abuse.

STUDENT'S NAME:	*DATE OF BIRTH:*
ADDRESS:	
CITY: *STATE/ZIP:*	*HOME NUMBER:*
STUDENT ID:	*CELL NUMBER:*

Information to be released/disclosed:

- □ Educational/Psychoeducational
- □ Health/Medical/Hospital
- □ Psychological/Psychiatric
- □ Financial
- □ Intake/Discharge/Progress Summaries
- □ Employment/Vocational
- □ HIV/AIDS
- □ Alcohol and/or Drugs
- □ Other (please specify):_____

Please DO NOT release/disclose the following information:_____

This information may be released/disclosed for the purpose of:

- □ Determining appropriate academic/housing/other accommodations at CCSU
- □ Coordinating Care/Treatment
- □ Other (please specify): _____

Name and address of the person(s)/organization(s) to whom the release/disclosure is to be made:

NAME/CREDENTIALS:	*TITLE:*
ORGANIZATION:	*TYPE:*
ADDRESS:	*RELATIONSHIP TO STUDENT:*
CITY: *STATE/ZIP:*	*PHONE NUMBER:*

I have been informed of the Central Connecticut State University's Student Disability Services policies regarding confidentiality and the release/disclosure of my personal information. I understand that I may inspect the information disclosed under this authorization and that I may receive a copy of this signed authorization form upon request. I understand that this authorization may be revoked in writing to Student Disability Services at any time, except to the extent that action has already been taken in reliance on this authorization. This authorization shall automatically expire one (1) year from the date of signature unless otherwise specified in the space provided here. DATE OF EXPIRATION: _____.

I hereby release the State of Connecticut, Central Connecticut State University, and its employees and agents from any liability arising from the release/disclosure to the parties designated herein of the information that Central Connecticut State University is herein authorized to release/disclose.

I understand that Central Connecticut State University's Student Disability Services may not condition the management of my case on the execution of this authorization except in cases of research-related treatment protocols or studies being conducted by outside third parties through Central Connecticut State University's Student Disability Services. In such cases, specific authorization for the research-related treatment protocols / studies must be signed as a condition of participation.

Notice to Recipients: As the recipient of this information, you may use this information only for the stated purpose. You may disclose this information to another party ONLY if there is written authorization from the student or his/her legal representative; as required or authorized by state and/or federal law.

If this disclosure contains information relating to alcohol or drug abuse, education, training, treatment, rehabilitation, or research, the following shall apply: This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations (Title 42 CFR Part 2) prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

Notice to Individual Requesting the Release/Disclosure*:*
Your signature below indicates that you understand that Central Connecticut State University's Student Disability Services is not a covered entity under the HIPAA Federal Privacy Regulations and is, consequently, not subject to those regulations.

Printed Name of Student:	
Signature of Student:	*Date:*
Printed name of Legal Representative:*	*Relationship to Student:*
Signature of Legal Representative:	*Date:*

** A copy of the personal representative's legal authority to act on behalf of the student is attached.*