COMMUNITY COLLEGE OF ALLEGHENY COUNTY
Disability Resources and Services
Email: DisabilityServices@ccac.edu
Phone: 412.237.4612
Fax: 412.237.2721

Authorization for Release of Confidential Information

Student Name: _____ ID#: _____

Current Address: _____ Birth Date: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Information to be released:				This information may be released for the purpose of:	
☐	Educational/Academic	☐	Medical	☐	Determining appropriate academic accommodations
☐	Mental Health	☐	Intake Documents	☐	Coordination of treatment
☐	Disability Documentation & Accommodations	☐	Other	☐	Other (please specify)

Please DO NOT disclose the following Information: _____

Name and Address of person/organization to whom the release is to be made:

NAME			TITLE
ORGANIZATION			TYPE
ADDRESS			RELATIONSHIP TO STUDENT:
CITY	STATE	ZIP CODE	PHONE

I have been informed of the Community College of Allegheny County's Office of Disability Resources and Services policies regarding confidentiality and the release 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 the Office of Disability Resources and Services at any time, except to the extent that action has already been taken in reliance on this authorization. I hereby release the Community College of Allegheny County and its employees and agent from any liability arising from the release to the parties designated herein of the information that the Office of Disability Resources and Services is herein authorized to release.

Notice to Student:
Your signature below indicates that you understand the Community College of Allegheny County's Office of Disability Resources and Services is not a covered entity under the HIPPA Federal Privacy Regulations and is, consequently, not subject to those regulations.

Duration of Authorization: I understand that this authorization shall automatically expire one (1) year from the date of signature unless indicated otherwise below:

☐ Indefinitely until revoked by me, in writing.
☐ Date of authorization _____
☐ Other (please specify) _____

I hereby authorize the Community College of Allegheny County's Office of Disability Resources and Services to release any and all records and information, which they may have concerning me to the person/ organization named below. It is my understanding that the information will be released in support of my enrollment as a student at the Community College of Allegheny County. I understand that this authorization is voluntary and that I may be selective in to whom and what information is disclosed. However, I am also aware that personal information relating to medical and mental health treatment may be disclosed.

Printed Name of Student:	
Student Signature:	Date:
Printed Name of Legal Representative*:	
Signature of Legal Representative:	Date:

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