



SIMMONS COLLEGE
DISABILITY SERVICES
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**AUTHORIZATION FOR RELEASE
 OF CONFIDENTIAL INFORMATION**

NAME: _____ **SOCIAL SECURITY NUMBER:** _____
ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

I, _____ HEREBY REQUEST/AUTHORIZE THE RELEASE OF CONFIDENTIAL INFORMATION
 FROM/TO DISABILITY SERVICES OF SIMMONS COLLEGE AND FROM/TO:

NAME: _____ **TITLE:** _____
ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **PHONE:** _____

I REQUEST THAT THE FOLLOWING INFORMATION BE RELEASED: (CHECK ALL THAT APPLY)

- | | |
|--|--|
| <input type="checkbox"/> IQ TEST RESULTS | <input type="checkbox"/> EDUCATIONAL TEST RESULTS |
| <input type="checkbox"/> DISABILITY DOCUMENTATION | <input type="checkbox"/> DIAGNOSIS STATEMENT |
| <input type="checkbox"/> TREATMENT HISTORY | <input type="checkbox"/> MEDICAL TEST RESULTS * |
| <input type="checkbox"/> MENTAL HEALTH INFORMATION * | <input type="checkbox"/> SUBSTANCE ABUSE INFORMATION * |
| <input type="checkbox"/> OTHER _____ | |

THE PURPOSE OF THIS DISCLOSURE IS:

- DETERMINE ELIGIBILITY FOR ACCOMMODATIONS
 UPDATE EXISTING FILE
 OTHER _____

I UNDERSTAND THAT I MAY REVOKE THIS RELEASE AT ANY TIME, OTHERWISE, THIS RELEASE WILL AUTOMATICALLY EXPIRE
 ONE YEAR FROM TODAY'S DATE, OR BY _____. NO INFORMATION RELEASED UNDER THE TERMS OF THIS
 AUTHORIZATION MAY BE RE-DISCLOSED WITHOUT THE WRITTEN PERMISSION OF THE CLIENT.

PLEASE DIRECT INFORMATION RELEASED TO _____

STUDENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

* MASSACHUSETTS PUBLIC HEALTH LAW G. L. C.111, S.70F AND FEDERAL
 REGULATIONS PROVIDE SPECIAL CONFIDENTIALITY PROTECTIONS FOR
 CERTAIN HEALTH RECORDS PERTAINING TO SUBSTANCE ABUSE, MENTAL
 HEALTH, AND HIV/AIDS. A SECOND WRITTEN CONSENT OF THE INDIVIDUAL
 SPECIFICALLY RELEASING THIS INFORMATION MUST BE OBTAINED. (MUST
 INITIAL AND SIGN BOTH IN THE BOX.) I SPECIFICALLY AUTHORIZE THE
 RELEASE OF INFORMATION RELATING TO:

- _____ SUBSTANCE ABUSE (ALCOHOL/DRUG ABUSE)
 _____ MENTAL HEALTH (INCLUDES PSYCHOLOGICAL TESTING)
 _____ HIV-RELATED INFORMATION (AIDS RELATED TESTING)

SIGNATURE: _____ DATE: _____

PERMISSION FOR FAX TRANSMISSION:

DISABILITY SERVICES CANNOT GUARANTEE
 THE CONFIDENTIALITY OF DOCUMENTS
 TRANSMITTED BY FAX. PLEASE INITIAL IF YOU
 WANT INFORMATION TO BE TRANSMITTED BY
 FAX.

Initials _____