

# INFORMATION RELEASE FORM

**Idaho State**  
**UNIVERSITY**  
Disability Services

This form authorizes Disability Services to release confidential information to a specified outside entity.

Rendezvous 125 • Pocatello, ID 83209 • (208) 282-3599 (p) • (208) 282-4617 (f)

## PART 1: REQUESTOR INFORMATION

Name:

Date of Birth:

Agency or Professional Name:

Agency or Professional Contact:

## PART 2: INFORMATION TO BE RELEASED (CHECK ALL THAT APPLY)

I authorize Idaho State University's Disability Services to disclose to the Agency or Professional named above the following health care information:

- All pertinent medical and/or psychological information and testing results and reports, including **specific diagnoses** of disability or disabilities in my records.
- My health information relating to the following conditions:
- My health information from the date \_\_\_\_\_ to the date \_\_\_\_\_.
- Other:

## PART 3: RELEASE STATEMENT

I am specifically requesting this information in order for the Agency or Professional named above to be able to verify my disability.

I understand that by signing this Release of Information and requesting Disability Services to provide the above information to another party, confidentiality of my information may not continue.

I may revoke this authorization in writing. If I do, it will not affect any actions already taken by the health provider listed above based on this authorization.

This authorization is good for 6 months from the date signed below, or from \_\_\_\_\_ to \_\_\_\_\_, whichever ends first. Please be advised that once the office discloses health information, the person or organization that receives it may re-disclose it with proper authorization.

## PART 4: AUTHORIZATION SIGNATURE

Signature:

Date: