NORTH IDAHO COLLEGE

Disability Support Services | 475 N. College Drive | Seiter Hall Room 100 | Coeur d'Alene, Idaho 83814
Phone (208) 665-4520 | FAX (208) 676-7202

Release of Information and Authorization for Sharing

I, (Student Name) _____, (Date of Birth) _____, hereby authorize the use or disclosure of my protected health and other pertinent information/documentation as described below:

1. **Authorized Persons to Disclose Protected Health Information/Documentation to NIC DSS**

_____
Name of Agency, Medical Physician, High School/College or Individual *Phone* *Fax*

_____
Address *City* *State* *Zip*

is authorized to disclose/release the following protected health information to North Idaho Disability Support Services, 475 N. College Drive, Seiter Hall Room 100, Coeur d'Alene, Idaho 83814.

2. **Description of Information/Documentation to be Disclosed/Released**

The Health Information that may be disclosed includes the following:

- ☐ Medical Records
- ☐ Treatment Records
- ☐ Mental Health Records
- ☐ Alcohol/Drug Treatment Records
- ☐ Other Records (specify) _____

- ☐ Verbal via email, phone or in person (*Please Provide Email*)_____
- ☐ ALL (All the Above)

3. **Purpose of the Use or Disclosure**

The purpose of this use or disclosure is to allow North Idaho College Disability Support Services to verify the student's disability and to have sufficient diagnostic and treatment information in order to assist the student towards the development of appropriate and effective educational accommodation(s).

4. **Validity of Authorization Form and Acknowledgment**

This authorization will expire one year from the date of the signature below. I understand that I can revoke this authorization at any time by writing to the professional/agency listed above or to the North Idaho College Disability Support Services, but that revoking this authorization will not affect disclosures made or actions taken before the revocation is received.

I have the right to refuse to sign this Authorization Form. I understand that Federal privacy regulations will no longer apply to the information disclosed and that the North Idaho College Disability Support Services may re-disclose the information. I am entitled to receive a copy of this authorization and a copy of this authorization may be utilized with the same effectiveness as an original.

_____ _____
Student Signature Date