



**PERMISSION TO DISCLOSE RECORDS
(HIPAA-COMPLIANT)**

I, _____, hereby authorize the following
(Student Name)

individuals and/or organizations to disclose all records in their possession regarding me to the Office of Disability Services (“ODS”) at Columbia University, Alfred Lerner Hall, 8th Floor 2920 Broadway, MC 2605 New York, NY 10027 (phone) 212.854.2388 and for ODS to release information it has to said individuals and/or organizations:

(Provider’s Information)

This authorization allows the above individuals and/or organizations to copy and send records to ODS and allows representatives of ODS to inspect the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the ODS staff.

This authorization encompasses *all* records pertaining to my condition, including “third party records” created by any other individuals or organizations.

Pursuant to HIPAA, the following are specified as part of this authorization:

- a. The purpose of disclosure is to assist Columbia University in determining whether I have a disability as defined by the Americans with Disabilities Act and what accommodations may be appropriate.
- b. This authorization expires one year after the date it is signed.
- c. I understand that I may revoke this authorization at any time by providing written notification to Columbia University or the individuals and organizations listed above, except to the extent that this authorization has already been relied upon.
- d. I have been informed that the individuals and organizations listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- e. I have been informed of the potential for information disclosed pursuant to this authorization to be subject to redisclosure by the recipient and to be no longer protected by HIPAA. I am also aware that any information disclosed to Columbia University is subject to other state and federal privacy laws.

Student Signature

Date: _____

Parent/Guardian Signature (If Student is Under Age 18)

Date: _____