

## PERMISSION TO DISCLOSE RECORDS (HIPPA-COMPLIANT)

I, \_\_\_\_\_, hereby authorize the following  
(Student Name)

individuals and/or organizations to disclose all records in their possession regarding me to the Center for Disability Resources (CDR) at Illinois Institute of Technology, 3424 S. State St., Room 1C3-2, Chicago, IL 60616 (phone) 312.567.5744 and for the CDR to release information it has to said individuals and/or organizations:

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(Provider's Information)

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

This authorization encompasses *all*

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 Illinois Institute of Technology is subject to other state and federal privacy laws.

\_\_\_\_\_ Date: \_\_\_\_\_  
Student Signature

\_\_\_\_\_ Date: \_\_\_\_\_  
Parent/Guardian Signature  
(If Student is Under Age 18)

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Send Form To:  
IIT Center for Disability Resources  
3424 S. State St., Room 1C3-2  
Chicago, Illinois 60616  
disabilities@iit.edu