Student Disability Services
Nampa Campus Willow Building C • 5520 E Opportunity Dr • Nampa, ID 83687
MS 2020, PO Box 3010 • Nampa, ID 83653

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Purpose of Disclosure: Our office is seeking documentation of your patient's disability to determine eligibility for academic accommodations as a student at CWI. Please fax or mail the released records at your earliest convenience.

LAST NAME FIRST NAME M.I. ______ DATE OF BIRTH ______ PHONE NUMBER ______

RELEASE FROM:	SEND TO:
Agency: ______ Provider: ______ Phone: ______ Fax: ______	Student Disability Services College of Western Idaho MS 2020, PO Box 3010 Nampa, ID 83653 Fax: 208-562-3478

Information to Disclose

I hereby authorize the disclosure and use of my protected health information as follows:

☐All pertinent medical and/or psychological information including ***ICD-11*** **and** ***DSM-5*** **diagnoses**

☐My health information relating to the following conditions: ______

for the following dates: ______ to ______

Release Statement

1. I understand that the information disclosed may be subject to re-disclosure by the person or facility receiving it and would then no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If information is disclosed from records protected by Federal confidentiality rules, the Federal rules prohibit the recipient from making further disclosure of this information unless further disclosure is expressly permitted, in writing, by the person to whom it pertains.
2. I may revoke this authorization by notifying Student Disability Services in writing of my desire to revoke it. However, I understand that any action already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.
3. I understand that this authorization is for the above stated purpose only and will not impact my healthcare benefits, treatments, payments, or enrollment.
4. I authorize CWI's Student Disability Services to speak with my treating physician or health care provider directly in regard to any questions s/he may have with respect to my disability and related to the performance of essential academic requirements and accommodations.

This authorization will expire one (1) year from the signed date.

______ STUDENT NAME ______ SIGNATURE ______ DATE