UAF UNIVERSITY OF ALASKA FAIRBANKS
Disability Services
(907) 474-5655 • Fax (907) 474-5688
www.uaf.edu • fydso@uaf.edu
America's Arctic University

## Authorization for Release of Protected Health Information

I, _____ hereby authorize the staff of **UAF Disability Services** to release records regarding my Disability Services and Accommodations to:

Person/Agency _____

Address _____

City/State/Zip _____

Phone #_____ Fax #_____

**Check the records** you wish to have released and the time period covered - and **initial each line indicating your consent.**

☐ Disability Services Records Date range_____ Initial here_____

**The purpose for this release of information is as follows:** ☐ At my request - signature below **or** as follows:

**This Authorization will be in effect for the current academic year as indicated by the date with your signature below - not to exceed 365 days.** You may withdraw or revoke this authorization to release information by writing at any time to the Director of UAF Disability Services, but the Disability Services office may continue to rely on this authorization to the extent that services have already been provided based on this authorization. Please also note that UAF Disability Services cannot control how the information released through this authorization will be used or whether it will be re-released or re-disclosed by the recipient of the information without further authorization from you.

Name (print)_____ Date of Birth_____ Soc. Sec. #_____

Address_____ Phone_____

_____ _____
Signature of student Date Witness/UAF staff person Date

_____ _____
Signature of student's parent or representative Date Relationship to student

Revised: 9/17/07