COLUMBIA HEALTH
Disability Services

Wien Hall, Suite 108A
411 W. 116th Street, Mail Code 3714
New York, NY 10027

Phone (212) 854-2388 (Voice/TTY)
Fax (212) 854-3448 disability@columbia.edu
www.health.columbia.edu/ods

PERMISSION TO DISCLOSE RECORDS (HIPAA-COMPLIANT)

I, ________________________________, hereby authorize the following individuals and/or organizations
(Student Name)
to disclose all records in their possession regarding me to Disability Services (DS) at Columbia University:

Columbia Health
Disability Services
Wien Hall, 1st Floor Suite 108A
411 W. 116th Street, MC 3714
New York, NY 10027
(phone) 212.854.2388
and for DS 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 DS and allows representatives of DS to inspect the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the DS 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.

______________________________________ Date: _______________
Student Signature

______________________________________ Date: _______________
Parent/Guardian Signature
(If Student is Under Age 18)

Revised August 2013