



Disability Resource Center
 Division of Student Affairs
 Clark Howell Hall
 The University of Georgia
 Athens, GA 30602
 706-542-8719

Name: _____

DOB: _____ Last 4 SSN#: _____

UGA ID: _____

Authorization for Release of Medical Information

I, _____, request and authorize the following professionals to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of postsecondary planning and disability accommodation implementation. A photocopy or fax of this authorization shall be as valid as the original document.

 Medical Professional

 Medical Professional

 Address

 Address

 City, State, zip code

 City, State, zip code

 Phone# Fax#

 Phone # Fax#

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of the Disability Resource Center. The revocation will not apply to action taken prior to that date.

 Date signed

 Student Signature (required)

 Date signed

 Guardian Signature (if student is less than 18 yrs old)

 Date signed

 Witness Signature

NOTE TO PARTY RECEIVING INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state laws, including without limitations, the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act. Federal Regulations prohibit you from making further disclosure of information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.