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TEXAS SOUTHERN UNIVERSITY

TEXAS SOUTHERN UNIVERSITY
Confidential Authorization to Release Medical Information/Records

I, _____ (Full Name), born _____ (Date of Birth) (_____ Student ID#), hereby authorize the release of medical information/records concerning me to Texas Southern University's Office of Disability Services.

I further authorize all health care professionals who have treated me to discuss the care and treatment they provided to me with the professional staff of Texas Southern University's Office of Disability Services, and waive any physician/patient privilege or confidentiality protection to which I may be entitled.

Due to my medical condition, I have requested certain course, classroom, and/or testing accommodations from Texas Southern University. Therefore, the primary purpose of this authorization is to provide the requisite medical documentation of my medical condition in order to establish the appropriate course, classroom, and/or testing accommodations that I require.

I authorize Texas Southern University's Office of Disability Services to disclose my information/records from Texas Southern University's Office of Disability Services (which may include medical information/records provided in the application process to Texas Southern University's Office of Disability Services) to the following agencies, departments, and/or service providers to the extent consistent with above-stated purpose of obtaining certain course and/or testing accommodations:

(Please initial all that apply))

_____ Appropriate TSU faculty, staff and administrators as needed

_____ Standard testing agents (e.g. for the TASP, GRE, LSAT, etc.) as needed

_____ Other institutions of higher learning as needed and specified below:

_____

_____ Other off-campus professionals as needed and specified below:

_____

_____ Other: _____

I also authorize Texas Southern University's Office of Disability Services to disclose my information/records from Texas Southern University's Office of Disability Services (which may include medical information/records provided in the application process to Texas Southern University's Office of Disability Services to the following persons)

(Please initial if applicable and list relationship with persons listed, such as, for example, your parents)

_____

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I understand that all of the medical information that I have authorized for disclosure pursuant to this authorization shall be held strictly confidential and will not be released without my permission, except to the extent allowed and authorized herein. I release Texas Southern University's Office of Disability Services, its directors, officers, administrators and employees from any and all legal responsibility or liability resulting from the disclosure of information/records that I have authorized to be disclosed.

I understand that this authorization is to remain in effect throughout my enrollment at Texas Southern University's Office of Disability Services. In the event I wish to revoke this authorization, I understand that such revocation shall be in writing and signed by me and shall be presented to Texas Southern University's Office of Disability Services, and that such revocation shall not affect information/records disclosed prior to the date such revocation is presented. I further understand that I may not maintain an action against Texas Southern University for any disclosures made by its agents in good faith reliance on this authorization if Texas Southern University's Office of Disability Services did not have written notice that the authorization was revoked.

A copy of this authorization bearing my signature shall be valid as the original.

_____ _____
Student Signature Date

_____ _____
Signature of Witness Date

If Student is under 18:

_____ _____
Signature of Parent Date

_____ _____
Signature of Parent Date

Note: Modification of this Form requires approval by the Office of General Counsel.