Authorization to Release Healthcare Information

I hereby authorize the healthcare provider listed below to communicate verbally and in writing, and to release health and medical records, to the accessibility services staff of the Center for Academic Support and Accessibility Services (CASAS) at Southern Connecticut State University (SCSU). The purpose of this communication and release of information is to assist CASAS in evaluating my request for accommodations and services at SCSU.

Name of Provider: _____

Clinic/Facility Name: _____

Provider Email: _____

Telephone: (_____) _____

Address: _____
Street Address

_____
City State Zip Code

Authorization

This authorization is valid for one calendar year and will expire automatically one year from the date below. I understand I may revoke this authorization at any time prior to such date by submitting written notice to CASAS.

Student Signature _____ Date_____

Student Name (Printed) _____ Student ID: _____