Authorization to Release Information to Arkansas Tech University Disability Services

Student Information: *(Please print or type)*

Name _____

Street Address _____

City / State / Zip _____

T# _____ Date of Birth _____ Telephone _____

Authorized Provider Information and Periods of Care:

Clinic Name and Location: _____

From (date) _____ To (date) _____ Provider Name (if applicable):_____

Please Release Information/Records that pertain to, or may impact the following accommodation(s):

☐ Entire Patient/Client Record	☐ Emotional Support Animal in ATU Housing (see attached ESA Provider Form)	☐ Temporary Medical Condition (i.e., injury/surgery dates, activity restrictions)
☐ Accommodated Tests/Exams	☐ Housing/Living Arrangements	☐ Class Attendance Flexibility/Absences
☐ Accommodations/Assistance for Reading Print Materials	☐ Meal Plan Changes/Special Dietary Requirements	☐ Due Date Flexibility
☐ Note-Taking Assistance	☐ Deaf and Hard of Hearing Assistance	☐ Other (specify):

Purpose for which the information will be used:

To assist in the determination of reasonable accommodations at Arkansas Tech University.

Send information to:

Office of Disability Services
Doc Bryan Building, Ste. 141
1605 Coliseum Drive
Russellville, AR 72802
Phone: (479) 968-0302
Fax: (479) 968-0375
Email: disabilities@atu.edu

- I accept responsibility for any use that may be made of the information as a result of this authorization and understand that I may revoke it in writing at any time.
- I understand that this authorization automatically expires one year from the date indicated below.
- I understand that treatment by my health care provider will not be conditioned on my signing this authorization.
- I understand that if I do not authorize Disability Services to obtain the information requested in this release, Disability Services may be unable to provide the services that I am requesting.
- I understand that I am entitled to a copy of this authorization.

Signature _____ Date _____