

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):

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