ARKANSAS TECH UNIVERSITY

Authorization to Release Information
to Arkansas Tech University
Disability Services/Deputy Title IX Coordinator

I hereby authorize (name, if applicable) _____

From: (clinic, hospital, or agency) _____

Contact number: (clinic, hospital, or agency) _____

☐ to release to ☐ to discuss with the Deputy Title IX Coordinator the information specified below:

Information to be released: (*please be specific)*

1. Date the patient gave birth
2. How long the individual needs to be out of work or school for medical recovery after giving birth
3. Any complications the mother or child experienced as a result of the birth that may necessitate a longer leave than usual

Send information to:

Assistant Dean of Student Wellness/Deputy Title IX Coordinator
Doc Bryan Suite 141
1605 Coliseum Drive
Russellville, AR 72802
Phone: (479) 968-0302
Fax: (479) 968-0375

Purpose for which the information will be used:
To assist in the determination of reasonable accommodations at Arkansas Tech University.

Identification: *(Please print or type)*

Name _____

Street Address _____

City / State / Zip _____

T# _____ Date of Birth _____ Telephone _____

- 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 _____