THE UNIVERSITY OF CHICAGO | Campus & Student Life
Student Disability Services

5501 S. Ellis Avenue, Chicago, IL 60637 773.702.6000 disabilities.uchicago.edu

AUTHORIZATION FOR RELEASE OF INFORMATION

As set forth below, I authorize the release of information to enable University officials to evaluate my accommodation request and determine what accommodations, if any, are reasonable and appropriate under the circumstances. Specifically, I authorize my physicians, psychiatrists/psychologists, other health care professionals, hospitals, clinics, agencies ("my providers") to release copies of my medical, mental health and service records related to my condition forms the basis for my accommodation request to Dr. Gregory Moorehead, Campus and Student Life Director for Student Disability Services, or his designee, at the University of Chicago, 5501 South Ellis Avenue, Room 101, Chicago, Illinois 60637, and to any outside consultant retained by the University. Nature of information to be released:

☐ any or all of the following:
☐ diagnosis and/or assessment results
☐ summary of treatment
☐ prognosis
☐ response to treatment/progress
☐ past and/or current accommodations
☐ recommended accommodations
☐ treatment plan and goals
☐ attendance/scheduling/transportation
☐ substance use/abuse information
☐ functional limitations/restrictions
☐ other:_____

I also authorize my providers to engage in a dialogue regarding these records and the functional limitations or restrictions caused by my condition with Dr. Moorehead, his designee and/or the consultant. I also authorize Dr. Moorehead, his designee, and/or the consultant to make a report of and discuss the findings with University officials who need to know the information so they can help determine what accommodations, if any, for my condition are reasonable. These officials may include, but are not limited to, staff in Campus and Student Life and the Office of the Provost who are directly involved in some aspect of the accommodation process. NOTE: If this authorization includes mental health and/or developmental disabilities information, recipients are forbidden from re-disclosing any of the information without my express consent.

This authorization shall expire one year after the date I sign this form or the date on which the evaluation process and determination are completed, whichever is sooner. I have the right to revoke this authorization at any time, although revocation will not have any effect on disclosures made before the revocation. I have a right to inspect and copy the information disclosed. I acknowledge that if I am unwilling to provide this release of information, it may not be possible to evaluate my condition accurately or to determine any reasonable accommodations for my condition.

AGREED:

_____ _____ _____
Student's printed name Student's signature Date