Disability Support Services
Rome Hall 801 22nd Street, NW Suite 102
Washington, DC 20052 Phone: 202-994-8250
dss@gwu.edu

Authorization for Release of Information

Student Name:_____

Student ID: _____

☐ I hereby authorize the following individuals and/or organizations to release all treatment records, relevant tests and case summaries in their possession regarding me to Disability Support Services (DSS) at George Washington University and for DSS to discuss such information in its possession to the individual and/or organizations listed below.

☐ I hereby authorize DSS to release all records pertaining to me to the names listed below and to discuss such information with listed individuals/organizations.

Name of individuals and/or organizations who will release or receive information

_____

_____

_____

This authorization allows the above individuals and/or organizations to copy and send records to DSS and allows representatives of DSS to review the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with DSS staff.
This authorization encompasses all records pertaining to my condition, including "third party records" created by any other individuals or organizations.

Pursuant to HIPAA, the following are specified as part of this authorization:

A. The purpose of disclosure is to assist GW in determining whether I have a disability as defined by the Americans with Disabilities Act and what accommodations may be appropriate.
B. This authorization expires one year after the date it is signed.
C. I understand that I have the right to revoke this authorization at any time by providing written notification to GW or the individuals and organizations listed above, and that revoking this authorization does not apply to information that has already been released by this authorization.
D. I have been informed that the individuals and organizations listed above may not condition treatment, payment on whether I sign this authorization.
E. I have been informed that the information disclosed may be re-disclosed if the recipient(s) of this information is not required by law to protect the privacy of the information, and the information is no longer protected by HIPAA privacy rules. I am also aware that any information disclosed to GW is subject to other state and federal privacy laws.

Student Signature: _____ Date:_____

Parent/Guardian Signature: _____ Date:_____
(If student is under age 18)