



# Authorization for Release of Information

Student Name: \_\_\_\_\_

Student ID: N \_\_\_\_\_

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 the Moses Center for Student Accessibility (CSA) at New York University, and for CSA to discuss such information in its possession to the individual and/or organizations listed below.

I hereby authorize the Moses Center 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 CSA and allows representatives of CSA to review the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the CSA 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 New York University 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 New York University 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 New York University is subject to other state and federal privacy laws.

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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