Heritage University

Office of Ability Services

Release of Information Form:

Americans with Disabilities Act of 1990 (ADA Policy)

"A disability can be a physical or mental impairment that substantially limits one or more major life activities of an individual." The ADA law prohibits discrimination and ensures that individuals with disabilities have "the same opportunities as everyone else to participate in the mainstream of American life - to enjoy employment opportunities, education, to purchase goods and services, to participate in State and local government programs and services." As an institution of higher education, Heritage University commits to make reasonable accommodations to students with disabilities.

READ FIRST: Before you decide whether or not to let the Office of Ability Services share some of your confidential information with another agency or person, an advocate at Heritage University will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want the Office of Ability Services to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that the Office of Ability Services has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow the Office of Ability Services to release some of my personal information to certain individuals or agencies.

I, _____, authorize the Office of Ability Services to share the following information with:

Who I want to share my information with:	Name: Specific Office at Agency: Phone Number:

The information may be shared: ☐ in person ☐ by phone ☐ by fax ☐ by mail ☐ by e-mail

☐ *I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.*

What information about me will be shared:	
Why I want my info shared: (purpose)	

I understand:

____ that I do not have to sign a release form. I do not have to allow the Office of Ability Services to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like the Office of Ability Services to release information about me in the future, I will need to sign another written, time-limited release.

____ that releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from the Office of Ability Services.

____ that the Office of Ability Services and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

This release expires on _____/_____/_____
Date

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time in writing.

Signed: _____ **Time:** _____ **Witness:** _____ **Date:** _____

Reaffirmation and Extension (if additional time is necessary to meet the purpose of this release)

I confirm that this release is still valid, and I would like to extend the release until _____ _____
New Date New Time

Signed: _____ **Date:** _____ **Witness:** _____