Authorization for Release of Information

Student Name: ____ Student ID: _________________

last name, first name, middle initial

1. Authorization

I authorize the identified person(s) and/or agencies to exchange relevant information or records with the Wheaton College authorized office(s) named on this form.

Wheaton College authorized office(s): ____

Name of Person or Entity

To whom access to records/information may be exchanged:

1. ____ _________________________________

Last name, first name Relationship to student

____ _________________________________

Telephone number Email

2. ____ _________________________________

Last name, first name Relationship to student

____ _________________________________

Telephone number Email

3. ____ _________________________________

Last name, first name Relationship to student

____ _________________________________

Telephone number Email

List individuals on this form ONLY if you intend to grant them the ***same type*** *of information access. Otherwise, if you wish to provide access to different information, please complete separate forms as necessary.*

Type of records/information to which access may be provided:

□ Academic (incl. but not limited to) grades, grade point average, enrollment level, course selection

□ Financial aid (incl. but not limited to) satisfactory academic progress, FAFSA, award amounts

□ Student account (incl. but not limited to) account balances, account charges, billing, payment

□ Conduct (incl. but not limited to) academic disciplinary processes, sanctions

□ Coordination of ongoing communication, support, care, and follow-up (i.e., care plan, support plan)

□ Accommodations (incl. but not limited to) diagnosis, accommodation needs, ADHD, and psychoeducational testing (see "Additional Information" section for additional required authorization to release this information)

□ Medical records (see "Additional Information" section for additional required authorization to release this information)

□ Mental health records (see "Additional Information" section for additional information required to release this information)

- Psychological Testing
- Treatment Summary
- Treatment of Discharge Plan
- Other (explain) ____

□ Other ____

2. Additional Information (if applicable)

Protected Information: If you consent to the release of any of the following information, please check all categories of information that may be disclosed pursuant to this Authorization for Release of Information.

☐ HIV/AIDS Testing Information or Test Results ☐ Genetic Testing and/or Genetic Counseling

☐ Psychiatric/Mental Health or Developmental Disabilities Information ☐ Substance Abuse/Alcohol Treatment

☐ Other ____

______________________________________ ______________________________

Student's Signature Date (mm/dd/yyyy)

3. Your rights and responsibilities

Please review and then sign to authorize the disclosure of the information as indicated above.

I understand that I may revoke this authorization at any time. Any such revocation will be valid, except for the release of information that occurred prior to this authorization being revoked. I may inspect and/or copy the information sought to be used or disclosed in this authorization as permitted by applicable law the federal privacy regulations. I understand that by signing this form, I am confirming my authorization that the above mentioned Wheaton College office(s) and its agents may use and/or disclose my educational and treatment records (check those that apply) and information described in this form to the person(s) and/or agency(s) named in this form. I understand that I may request a copy of this authorization after signing below.

This authorization is voluntary and I am under no obligation to sign this form and no organization/department may condition treatment, payment, enrollment, or eligibility for benefits on signing this form. I understand that refusing to sign this form does not stop disclosure of information that is otherwise permitted by law without my specific authorization, consent or permission. I understand that in order to revoke this authorization form, *a written request* must be sent to the Wheaton College office where this authorization form was signed. I understand that revocation of this authorization will not affect any disclosures or actions taken by Wheaton College before receiving the written notice of revocation. I understand that this form is an occurrence-based form and is used only for medical and mental health records if I am a current patient in Student Health Services or a client in the Wheaton College Counseling Center, respectively. The form is available for use by all students who are in communication with a Wheaton College office or employee where a release of information is needed.

4. Certification

I understand that this authorization may be withdrawn by me at any time and that I may modify this authorization through submission of a new Authorization for Release of Information Form. This form is valid for 12 months from date of signing.

Student Signature: ____________________________________ Date: ____________________

Wheaton College office where this authorization form was signed: ______________________________________

5. Revocation (to be filled out only if student would like to revoke this authorization)

I would like to revoke this authorization to release information to those named on this form.

Student signature ______________________ Date:_________ Witness signature _____________________ Date:__________