Mount Saint Mary College

330 Powell Avenue, Newburgh, New York 12550 • www.msmc.edu

RELEASE OF INFORMATION FOR DISABILITY SERVICES

The Mount Saint Mary College Office of Disability Services collaborates with other college departments to provide students with comprehensive accommodations and disability supports to help them reach their full potential. There may be times when the student may benefit from coordination between Disability Services and one of the other departments within the College. By completing and signing the form below, I hereby authorize Mount Saint Mary College Disability Services to release/exchange information concerning my diagnosis/ disability to the department or person within the College that are listed below.

Student Information

Name: _____DOB: _____ SSN: _____

Address: _____

Street Address / P.O. Box City State Zip

Phone Number: _____

Release Information to the following Department(s) or Person (s):

☐ Disability Services

☐ HEOP

☐ Office of Student Success – Academic Coaches

☐ Residence Life

☐ Dietary Services/ Operations Department/ Parkhurst Dining Services

☐ Safety and Security

Specific type of information to be disclosed/ exchanged:

☐ Disability/Accommodations Information

☐Residence Hall Considerations

☐Academic Considerations

☐Dietary Considerations

☐ Other: _____

I understand that the information is to be used for:

☐Accommodation Determination

☐Other: _____

Unless otherwise revoked, this Authorization will expire on the following date, event, or condition:

_____
_____
_____

As the individual signing this Authorization, I understand that I am giving my permission to the above-named person or institution to use or disclose the confidential health information specified above. I understand that I may revoke this Authorization at any time by notifying Mount Saint Mary College, Office of Disability Services, 330 Powell Avenue, Newburgh, NY 12550. I understand that the revocation is only effective after it is received by Mount Saint Mary College Counseling Services. I understand that any use or disclosure made prior to the revocation under this Authorization will not be affected by revocation. If I fail to specify an expiration date or event or condition above, this authorization will expire automatically in twelve (12) months from the date of my signature below.

I may refuse to sign this Authorization. I understand that Mount Saint Mary College Disability Services will not share any specific diagnosis or disability information without receiving my signature on this Authorization.

I understand that any disclosure pursuant to this Authorization may be subject to re-disclosure by a recipient of such information, and that it is possible that once disclosed the privacy of the information may no longer be protected by privacy laws.

I have read and understand the information in this Authorization form:

Printed Name: _____

Unless otherwise revoked, this Authorization will expire on the following date: _____

Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

Witness Printed Name: _____