UNIVERSITY OF MONTANA
OFFICE FOR DISABILITY EQUITY

RELEASE of INFORMATION AUTHORIZATION

Name: Mary Poppins UM ID: 790000000

Date of Birth: 01/01/2005 Phone: 4061111111

Address: Aber Hall 000, Missoula, MT 59801 UM Email Address: mary.poppins@umontana.edu

I authorize the Office for Disability Equity at the University of Montana to (Check the appropriate box below):

☑ **Receive my protected information from the following location:**

Or

☐ **Release my protected information to the following location:**

Name: [your provider's name] Agency Name: Curry Health Center

Address: 634 Eddy Avenue, Missoula, MT 59812

Phone: 4062432122 Fax: _____

Purpose of the Disclosure (Check the appropriate box below):

☑ Disability documentation/Verification for the Office for Disability Equity's eligibility
☐ Service coordination
☐ My personal records
☐ Other _____

I understand that my records may contain information regarding the diagnosis or treatment of HIV/AIDS, sexually transmitted disease, drug and/or alcohol abuse, mental illness, or psychiatric treatment. I give my specific authorization for these records to be released.

Type of Information to Be Received/Released-Other Request or Limitation

☑ Medical Records
☐ Psychiatric/Psychological Diagnostic Reports (i.e. ADHD, Learning Disability, Mental Illness, etc.)
☐ Psychiatric/Psychological Treatment or Progress Notes
☐ Drug/Alcohol abuse/treatment and diagnosis
☐ Sexually transmitted disease
☐ HIV/AIDS diagnosis/treatment
☐ Academic Information
☐ Other request or limitation (specify) _____

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Office for Disability Equity, up to the extent that the disclosure has not already been made prior to revocation. Authorization will expire in 6 months unless otherwise specified. Expiration Date:

Signature: Mary Date: 2/1/2024