UNIVERSITY OF MONTANA
OFFICE FOR DISABILITY EQUITY

RELEASE of INFORMATION AUTHORIZATION

Name: UM ID:

Date of Birth: Phone:

Address: UM Email Address:

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: Agency Name:

Address:

Phone: 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: ______________________________ Date: