File Authorization / Disclosure of Information

Student Name:_________________________________ ID Number:_____________________

NOTE: Information will NOT be given over the phone. Persons requesting information in office must verify identity. All other requests must be in writing with a signature from the authorized person. This authorization is in effect until cancelled in writing by the student.

Please note that this form does NOT serve as a Release of Information for Integrated Student Health Center information, as those records are protected under HIPPA. If you would like to grant permission for ISHC staff to discuss medical/counseling issues with someone, please complete the Release of Information form FROM ISHC, located on the website at http://www.oit.edu/campus-life/student-health/forms.

I authorize the following persons/institution/agency to receive information regarding my student records (please print):

		Relationship
1.		Mother Spouse
First Name	Last Name	Father