File Authorization / Disclosureof 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 tp fOther

Phone Number ______________ Address ______________

2. ______________ ______________

First Name Last Name

Relationship
☐ Mother ☐ Spouse
☐ Father ☐ Other

Phone Number ______________ Address ______________

3. ______________ ______________

First Name Last Name

Relationship
☐ Mother ☐ Spouse
☐ Father ☐ Other

Phone Number