

### Authorization to Use and Disclose Protected Health Information

The purpose of this disclosure is to support the student's request for academic accommodations by establishing eligibility for services in accordance with Federal Law and DVC policy.

Student Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Name of Person/Agency holding Records: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

I authorize the above person/agency to release specific records, and/or protected health information, to Diablo Valley College, Disability Support Services as indicated below:

- Complete and return the attached "Verification of Disability" form
- Attach relevant diagnostic reports: \_\_\_\_\_

I understand and agree that this information will be used or disclosed if I place my initials in the applicable space next to the type of information:

- Mental Health Information
- HIV/AIDS Information
- Drug/Alcohol diagnosis, treatment or referral information

**Disclosed Protected Health Information to:**

Disability Support Services  
Diablo Valley College  
321 Golf Club Rd  
Pleasant Hill, CA 94523

**SECURED FAX (925) 687-1829**  
Attn: Susan Garcia  
Phone: (925) 685-1230 ext. 2546

I understand that the information used or disclosed according to this authorization may be subject to re-disclosure and no longer protected under federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health, genetic testing and drug/alcohol diagnosis, treatment or referral information. I understand that I may revoke this authorization at any time by submitting a written request to the address listed above. If I revoke this authorization, the information described may no longer be used or disclosed for the purposes explained. Any disclosure already made with my permission cannot be undone. This authorization will expire in one year, or upon completion or departure from my studies at Diablo Valley College.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent: \_\_\_\_\_ Date: \_\_\_\_\_

(If student is under the age of 18)

This authorization intends to be HIPPA compliant in order to obtain protected health information (PHI) regarding this student's request for services. Regulations regarding the use and further disclosure of PHI are determined by the federal and state confidentiality requirements.

Fees associated with duplication of documents are the responsibility of the student. DVC will not pay for document completion or duplication costs.

Alternate format available upon request