

OHIO  
NORTHERN  
UNIVERSITY

**FORM 104**

**Ohio Northern University  
HIPAA Compliant Authorization  
for the Release of Protected Health Information**

The Individual who is the subject of the information:

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**Name**

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**Address**

does hereby **AUTHORIZE THE DISCLOSURE** of specified health information as follows:

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**Name of Provider**

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**Address of Provider**

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**Phone and fax numbers of Provider**

**is hereby authorized to release to:**

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Disability Services Coordinator, Tracey Harris  
Ohio Northern University  
525 South Main Street  
Ada, OH 45810

**Phone:** \_\_\_\_\_

**Fax:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**the following health information:**

Information described on the attached Form 102.

**for the following purpose:**

Evaluation of my request for accommodations.

I understand that my express consent may be required for the release of information relating to sexually transmitted diseases, AIDS, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If I have been tested, treated, or diagnosed in connection with any such injury, disease, or illness, Provider is specifically authorized to release those health records (including psychotherapy notes) relating to such diagnosis, testing, or treatment, as directed in this Authorization. I understand that some of this health information may be protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent.

This Authorization is a free and voluntary act by me. I understand that, if the Provider is rendering services to me solely for the purpose of disclosing the health information generated thereby to the person designated in this Authorization, my failure to provide this Authorization may result in a denial of service by the Provider. Otherwise, I understand that my Provider cannot condition my treatment on my signature on this Authorization.

This Authorization will be valid for one year or until I revoke this Authorization, whichever occurs first. I know that I may revoke this Authorization at any time, except to the extent that the Provider may have taken action in reliance thereon, by notifying the Provider in writing at the address given above. I also understand that the Provider cannot limit or control the subsequent use, reproduction, or dissemination of the health information I have authorized to be released. A copy of this Authorization is as valid as the original.

**Individual's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Print name:** \_\_\_\_\_