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AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize my physicians, psychiatrists/psychologists, other health care professionals, hospitals, clinics, agencies to release copies of my medical and service records having to do with my condition to the Director of Student Disability Services, or their designee, at Northeastern Illinois University, 5500 North St. Louis Avenue, Chicago, IL 60625.

I authorize those parties to respond to questions regarding these records or my condition or treatment asked by the Director of Student Disability Services or designee, or the consultant. I understand that such questions are asked for the purpose of evaluating my condition to provide University officials with sufficient information to determine accommodations, if any, may be reasonable and appropriate under the circumstances.

I also authorize The Director of Student Disability Services, designee, or the consultant to make a report of and discuss the findings with appropriate University officials who are involved in determining what accommodations, if any, to my condition may be reasonable under the circumstances. Such officials may include, but are not limited to, individuals in Student Affairs and the Office of the Provost.

This authorization shall be valid until the evaluation process and determination are fully and finally completed or until I revoke this authorization in writing. I understand that if I am unwilling to provide this release of information, it may not be possible to evaluate my condition accurately or to determine any reasonable accommodations to my condition.

Signed:_____ Dated:_____

Student's signature

Print:_____

Student's name