

# Student Affairs Case Management

**4202 East Fowler Avenue, ADM 151**

### Tampa, FL 33620-6970

### Telephone: (813) 974-6130

### Fax: (813) 905-9918

## AUTHORIZATION FOR RELEASE OF INFORMATION

##

This form when completed and signed by you, authorizes the release of

protected information in a potentially protected health or academic record

from the Student Affairs Case Manager to an entity you designate

**NAME (Please Print)**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**University ID** #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Last 4 SSN#:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# I authorize Student Affairs Case Management at the University of South Florida to release general information (e.g., attendance at appointments) as well as supportive care, social service, academic, and/or referral assistance needs from my record to: [*specify agency or entity below*]

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| --- |
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|  |

I am requesting that my provider release this information for the following reasons:

**\_\_\_\_\_\_** at my request **(**if you are the client and you do not want to state a specific purpose)

\_\_\_\_\_\_ for the purposes of: 🞏 case coordination & services planning

 🞏 other: (please specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

You have the right to revoke this authorization, in writing, at any time by sending such written notification to my office address. However, your revocation will not be effective to the extent that I have taken action in reliance on the authorization.

I understand that my case manager generally may not condition the participation in services upon my signing an authorization.

I understand that information disclosed due to the authorization may be subject to redisclosure by the recipient of the information.

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Signature of Student Date

This authorization is valid for **ninety (90) days** from the date of signing by the client **or** until the following date:

Date of Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the authorization is signed by a personal representative of the client, a description of such representative's authority to act for the client must be provided.