



RESIDENTIAL HOUSING

Authorization for Release of Confidential Information

OHIO UNIVERSITY

Department of Residential Housing

060 Chubb Hall, Athens, Ohio 45701

Phone: (740) 593-4090 Fax: (740) 593-4089

Student Name: _____ Student PID #: _____

Clinician Name: _____ Clinician Phone #: _____

In order for the Assistant Director to objectively evaluate, additional details might be needed from the clinician in charge of your treatment. By signing this form, you understand that you are providing your clinician the right to disclose any information directly to the Residential Housing Office that is necessary to assist with the exemption/termination review process.

This authorization shall remain in effect for:

_____Thirty (30) days _____Sixty (60) days _____Ninety (90) days

- I understand that the information used or disclosed as a result of this authorization may be re-disclosed by the recipient and no longer protected by HIPAA Privacy Rules.
- You have the right to revoke this authorization, in writing, at any time by sending such written notification to the Assistant Director of Residential Housing. However, your revocation will not be effective to the extent that we have taken action in reliance on the authorization.

Printed Name of Student

Witness Signature

Signature of Student

Date