OFFICE of ACCESSIBILITY SERVICES
PITT COMMUNITY COLLEGE

PO Drawer 7007 • Greenville, NC 27835-7007 • Phone (252) 493-7595 • Fax (252) 321-4345 • Everett-114

PERMISSION TO DISCLOSE RECORDS

(Office of Accessibility Services requesting records from external individuals and agencies)

I_____Date of Birth_____
Name (Please Print)

Address:_____
Street and Number City State Zip Code

Last 4 digits of SSN:_____ hereby authorize the following designated individual and/or entity

Agency/Provider:	Contact Person:
Address:	City/State/Zip:
Phone:	Fax:

to disclose my disability-related records in their possession

- ☐ including(*initial each*): ____Substance Abuse ____Mental Health and/or ____HIV-related documentation
- ☐ specifically about:_____
- ☐ from (*specify date range)**:_____to_____

*document must be within last 3 years (per federal guidelines)

This authorization allows the above designated individual and/or entity to copy and send records to PCC Office of Accessibility Services and allows an OAS authorized representative to review the records and discuss my condition with said individual and/or entity if necessary to determine reasonable accommodations. This authorization encompasses records pertaining to my condition, including "third party records" created by any other individual or organization.

Pursuant to HIPAA, the following are specified as part of this authorization:

- The purpose of disclosure is to assist Pitt Community College in determining whether I have a disability as defined by the Americans with Disabilities Act and what accommodations may be appropriate.
- This authorization expires one year after the date it is signed.
- I understand that I may revoke this authorization at any time by providing written notification to Pitt Community College or the individual and organization listed above, except to the extent that this authorization has already been relied upon.
- I have been informed that the individual and organization listed above may not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization.
- I have been informed of the potential for information disclosed pursuant to this authorization to be subject to re-disclosure by the recipient and to be no longer protected by HIPAA. I am also aware that any information disclosed to Pitt Community College is subject to other state and federal privacy laws.

_____
Student Signature (Parent/*Guardian if under Age 18)* Date

_____
Accessibility Services Staff Date