GATEWAY TECHNICAL COLLEGE
EMPLOYEE AUTHORIZATION TO RELEASE
MEDICAL AND HEALTH CARE INFORMATION

Student/Patient Name:

Gateway Technical College requires information to evaluate your medical condition in connection with your education. In order to obtain relevant information from your health care provider, it is necessary for you to sign this authorization form. We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information to the fullest extent possible. Please read the information below carefully before signing this form. If you have any questions, please contact your DSS Instructor.

USE AND DISCLOSURE COVERED BY THIS AUTHORIZATION

I authorize the individual or entity named below to disclose to Gateway Technical College any medical or other health care information relating to mental health conditions or disabilities.

HEALTH CARE PROVIDER INFORMATION

Health Care Provider/Institution Name:	
Contact Name:	
Address:	
Phone Number:	
Fax Number:	

SPECIFIC UNDERSTANDINGS

By signing this authorization form, I authorize the use or disclosure of my health information as described above. In accordance with applicable law, this information may be used by Gateway Technical College in regard to determining appropriate ADA accommodations.

I understand that I have a right to refuse to sign this authorization. If I do not sign this form, I understand that it may adversely affect Gateway's ability to assess the underlying issue specified above, including but not limited to any related leave, absence and/or accommodation issues.

I understand that I have a right to see and copy the information described on this authorization. I also have a right to receive a copy of this form after I have signed it.

I authorize the use of a photocopy of this authorization in lieu of any original signature and agree that this authorization shall remain valid until otherwise revoked by me or until such time that Gateway Technical College no longer needs to assess my medical information for the reason specified above, but no longer than one year from the date I sign this authorization. I understand that I also have the right to revoke this authorization at any time by written letter to the health care provider I have authorized to release information. I understand that, in order to be effective, any revocation must be in writing and delivered to the Disability Support Service Instructor. Revoking this authorization does not affect the release of any information prior to my revocation. In addition, I understand that revoking this authorization may affect my right to a leave of absence, reasonable accommodation, return to work, or other job-related benefit.

SIGNATURE

I have fully read this authorization form and had sufficient opportunity to ask any questions before signing. By signing below, I acknowledge that I have read, fully understand and agree to all of the above.

_____

Print Name of Student Authorizing Release of Medical Information

_____

Signature of Student Authorizing Release of Medical Information (or Personal Representative)

If signature is of Personal Representative, print name and explain his/her Relationship/Authority to the employee whose medical information is being released (*e.g., legal guardian)*

_____

Date