Please fill out sections marked by an arrow (→ ←)

Wheaton College

Authorization for Release of Information

→ Student Name: Jones, SULLY ID: 82399 ←
last name, first name, middle initial

1. Authorization
I authorize Wheaton College to release my records and the information contained in those records as indicated on this form.

Name of Person or Entity (To Whom Access to Records/Information May Be Provided): **Relationship to Student**

→ 1. Jones, Matt — Father ←
Last name, first name

→ 555-123-4567 — dad@Gmail.com ←
Telephone Number *Email*

→ 2. Smith, Betty — mother ←
Last name, first name

→ 555-234-5678 — mom@gmail.com ←
Telephone Number *Email*

List two individuals on this form ONLY if you intend to grant them the same type of information access. Otherwise, please complete a separate form for each individual. If you wish to provide access to more than two individuals, please complete additional forms as necessary.

Type of Records/Information To Which Access May Be Provided:

- ☐ Academic (incl. but not limited to) grades, grade point average, enrollment level, course selection
- ☐ Financial aid (incl. but not limited to) satisfactory academic progress, FAFSA, award amounts
- ☐ Student account (incl. but not limited to) account balances, account charges, billing, payment
- ☐ Conduct (incl. but not limited to) academic disciplinary processes, sanctions
- ☐ Accommodations (incl. but not limited to) diagnosis, accommodation needs, ADHD and psychoeducational testing (see "Additional Information" section for additional required authorization to release this information)
- ☐ Medical records (see "Additional Information" section for additional required authorization to release this information)
- ☐ Mental health records (see "Additional Information" section for additional information required to release this information)
    - ○ Psychological Testing
    - ○ Treatment Summary
    - ○ Treatment of Discharge Plan
    - ○ Other (explain) _____
- → ☑ Other Hospitalization information

Records/Information to be used for (explain reason(s) for release of records/information)

→ Coordination of care

2. Additional Information (if applicable):

Protected Information: If you consent to the release of any of the following information, please check all categories of information that may be disclosed pursuant to this Authorization for Release of Information.

☐ HIV/AIDS Testing Information or Test Results ☐ Genetic Testing and/or Genetic Counseling

☐ Psychiatric/Mental Health or Developmental Disabilities Information ☐ Substance Abuse/Alcohol Treatment

☐ Other _____

_____ _____

Student's Signature Date (mm/dd/yyyy)

_____ _____ _____

Witness' Signature Witness' Printed Name Date (mm/dd/yyyy)

3. Your rights and responsibilities

Please review and then sign to authorize the disclosure of the information as indicated above:
I understand that I may revoke this authorization at any time. Any such revocation will be valid, except for the release of information that occurred prior to this authorization being revoked. I may inspect and/or copy the information sought to be used or disclosed in this authorization as permitted by applicable law the federal privacy regulations. I understand that by signing this form, I am confirming my authorization that the above mentioned Wheaton College office(s) and its agents may use and/or disclose my educational and treatment records (check those that apply) and information described in this form to the person(s) and/or agency(s) named in this form. I understand that I may request a copy of this authorization after signing below. This authorization is voluntary and I am under no obligation to sign this form and no organization/department may condition treatment, payment, enrollment, or eligibility for benefits on signing this form. I understand that refusing to sign this form does not stop disclosure of information that is otherwise permitted by law without my specific authorization, consent or permission. I understand that in order to revoke this authorization form, *a written request* must be sent to the Wheaton College office where this authorization form was signed. I understand that revocation of this authorization will not affect any disclosures or actions taken by Wheaton College before receiving the written notice of revocation. I understand that this form is an occurrence-based form and is used only for medical and mental health records if I am a current patient in Student Health Services or a client in the Wheaton College Counseling Center, respectively. The form is available for use by all students who are in communication with a Wheaton College office or employee where a release of information is needed.

4. Certification

I understand that this authorization may be withdrawn by me at any time and that I may modify this authorization through submission of a new Authorization for Release of Information Form. This form is valid for 12 months from date of signing.

→ Student Signature Sully Jones Date: 3/22/17 ←

→ Witness Signature _____ Date: 3.22.2017 ←

→ Wheaton College office where this authorization form was signed: Student Development

_____ _____

Parent, Guardian or Authorized Representative Signature (If applicable) Authorized Representative Printed Name

5. Revocation (to be filled out only if student would like to revoke this authorization)

I would like to revoke this authorization to release information to those named on this form.

Student Signature _____ Date:_____ Witness Signature _____ Date:_____