Appendix II: Authorization for Release of Health Information and Health Care Provider Verification Form

SECTION I: For Completion by the Student

Student's Name: ____
Student's Address: ____
City/Town: _______________________ Zip Code: ___________

Student's Telephone number: (H) _____________________________ (C) __________________

Student's email address: _____________________________

X Number: ____

I, or my authorized representative, request that health information regarding my care and treatment be released to St. John's University, 8000 Utopia Parkway, Queens, New York 11439 as set forth on this form. In accordance with New York State Law and the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I understand that:

1. This authorization may include disclosure of information relating to mental health treatment.
2. I have the right to revoke this authorization at any time by writing to the health care provider listed below. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
3. Information disclosed under this authorization might be redisclosed by the recipients, and this redisclosure may no longer be protected by federal or state law.

Health Care Provider's Name:	____	
Health Care Provider's Address:	____	
	City/Town: _______________________	Zip Code: ______________
Health Care Provider's Telephone number:	(O) _____________________________	(F) ____________________
Health Care Provider's email address:	____	

____   _____________
Student's Signature   Date

____   _____________
Parent or Guardian's Signature (if student is under 18)   Date

SECTION II: For Completion by the Health Care Provider

The student whose name appears above has requested an Assistance Animal, which is an animal that provides emotional support, well-being, or comfort. Answer, fully and completely, all applicable parts. Your answer should be based upon your medical knowledge, experience, and examination of the student. Do not provide information about genetic tests, as defined in 29 C.F.R. § 1635.3(f), genetic services, as defined in 29 C.F.R. § 1635.3(e), or the manifestation of disease or disorder in the student's family members, 29 C.F.R. § 1635.3(b).

Provider's Name: ____
Provider's Address: ____
____

City/Town: _______________ Zip Code: ________

Provider's Telephone/Fax (O) _____________________ (F) __________________

Provider's License: ______________________
Licensure State ______________________ Licensure # ______________________

This student has the following disability[1]:
____
____
____
____
____.

An Assistance Animal will help the student's disability in the following ways:
____
____
____
____
_____________.

CERTIFICATION

By signing below, I certify that the answers provided in response to the above questions are based on my own personal knowledge of the relevant medical facts from my own examination of the student or based on my own review of the relevant medical documentation, and my answers represent my professional medical opinion.

____ _______________________________________
Health Care Provider's Name (Please Print) Specialty

____ Date: __________________
Health Care Provider's Signature

[1] A person with a disability is one who has a physical, medical, mental or psychological impairment, or a history or record of such impairment.