ST. JOHN'S UNIVERSITY
STUDENT ACCESSIBILITY SERVICES

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 Emotional Support 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 Emotional Support Animal will help the student's disability in the following ways (be as detailed as possible):

_____

_____

_____

_____

_____.

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.