HARVARD LAW SCHOOL | Accessibility Services

Release of Information

Student Information

Name: _____ HUID: _____

Individual(s) and/or Organization(s) Information

I give permission to the individual(s) and/or organization(s) named below to release and receive medical information related to accommodations to Accessibility Services at Harvard Law School.

_____

_____

_____

_____

_____

Agreement

I agree that:

1. I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization.
2. I may revoke this authorization at any time by notifying Accessibility Services at Harvard Law School. However, such revocation will not affect any actions taken before the revocation was received or actions taken on reliance thereon.
3. I understand that information on file at Accessibility Services is protected under the Family Educational Rights and Privacy Act (FERPA).
4. I understand that my healthcare provider may also have his or her own form that I may need to complete to allow the release of medical information.

Student Signature

Name: _____ Date: _____