Faulkner University complies with all provisions of FERPA and HIPAA dealing with the release and/or receipt of medical and educational records within the Accessibility Office. No information concerning individuals receiving accessibility services, except as otherwise provided by law, will be released without the written consent of the student. It is the responsibility of the student to provide the Center of Accessibility (CA) with the necessary specific authorization and consent.

Please be advised that your disability record constitutes privileged information that is protected by the laws of the State of Alabama and may contain information protected under FERPA and HIPAA. Information shared with faculty consists of a list of required accommodations on a need to know basis. Faulkner University Police Department, and Student Services will be given a copy of this release form. Please list at least one emergency contact that can be contacted in case of an emergency. No disability specific information is shared by CA, with Faulkner University faculty and / or staff. If not revoked earlier, this consent form expires upon graduation, or as specified below.

I, _____, herein revoke my permission for the Center of Accessibility to release any information regarding my status.

_____ _____

Signature of student receiving services Date

Student's Name: _____ Faulkner ID: _____

I give my permission for CA to release to or receive information regarding educational needs created by my disability to the individuals listed below:

NAME & RELATIONSHIP TO STUDENT	Receive Information From		Release Information To	
	YES	NO	Yes	No
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐

Authorization to Release Information to Designated University Offices

I understand that the Center for Accessibility may need to communicate with certain university offices to facilitate accommodation, ensure student safety, address housing-related needs, or respond to

emergencies. By initialing below, I authorize the Center for Accessibility to release and/or receive information regarding my disability-related educational needs as indicated.

University Office	Authorize Release of Information	Student Initials
Faulkner University Police Department	□ Yes □ No	_____
Director of Housing (or Designee)	□ Yes □ No	_____
Student Services (or Designee)	□ Yes □ No	_____

Purpose of Disclosure: Information may be shared only as necessary to facilitate approved accommodation, address housing-related accommodation needs, respond to health or safety concerns, coordinate support services, or fulfill legitimate educational interests consistent with applicable law and university policy.

I understand that:

- Authorizing disclosures to these offices is voluntary.
- Refusing authorization may limit the University's ability to coordinate certain accommodations, housing arrangements, or emergency responses.
- Disability-specific information will be disclosed only when necessary and only to individuals with a legitimate educational interest or other legal basis for access.
- This authorization may be revoked at any time by submitting a written request to the Center for Accessibility, except to the extent that action has already been taken in reliance upon this authorization.

Emergency Contact (Required)

Name: _____

Relationship: _____

Phone Number: _____

I have read, or have had read to me and fully understand the terms and conditions of this agreement.

I do, freely, voluntarily, and without coercion agree to those terms and conditions contained herein.

_____ _____

Printed name Date

_____ _____

Signature Student ID

To be filled out by Faulkner University's CA staff only:

Date received from student	Date filed	Reviewed by: