FORM 105

Ohio Northern University College of Law
HIPAA Compliant Authorization
for the Release of Protected Health Information

The Individual who is the subject of the information:

_____

Name Address

does hereby AUTHORIZE THE DISCLOSURE of specified health information as follows:

_____
Name of Provider

_____
Address of Provider

_____

_____
Phone and fax numbers of Provider

is hereby authorized to release to:

Bryan H. Ward
Associate Dean for Academic Affairs
Ohio Northern University College of Law
525 South Main Street
Ada, OH 45810

Phone: (419) 772-2212
Fax: (419) 772-2318
E-mail: b-ward1i@onu.edu

the following health information:

Information described on the attached Form 102.

for the following purpose:

Evaluation of my request for examination accommodations.

I understand that my express consent may be required for the release of information relating to sexually transmitted diseases, AIDS, mental illness, psychiatric treatment, and/or drug or alcohol abuse treatment. If I have been tested, treated, or diagnosed in connection with any such injury, disease, or illness, Provider is specifically authorized

to release those health records (including psychotherapy notes) relating to such diagnosis, testing, or treatment, as directed in this Authorization. I understand that some of this health information may be protected under the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent.

This Authorization is a free and voluntary act by me. I understand that, if the Provider is rendering services to me solely for the purpose of disclosing the health information generated thereby to the person designated in this Authorization, my failure to provide this Authorization may result in a denial of service by the Provider. Otherwise, I understand that my Provider cannot condition my treatment on my signature on this Authorization.

This Authorization will be valid for one year or until I revoke this Authorization, whichever occurs first. I know that I may revoke this Authorization at any time, except to the extent that the Provider may have taken action in reliance thereon, by notifying the Provider in writing at the address given above. I also understand that the Provider cannot limit or control the subsequent use, reproduction, or dissemination of the health information I have authorized to be released. A copy of this Authorization is as valid as the original.

Individual's Signature:_____

Date:_____

Print name:

_____

If applicable:

Personal Representative Signature: _____

Date:_____

Print name:

_____

Description of Personal Representative's authority to act for the Individual:

_____