

Authorization for Release of Information

Student Name: _____ Student ID: _____

1. Authorization

I authorize the identified person(s) and/or agencies to exchange relevant information and/or records with the Wheaton College authorized office(s) holding the records identified below:

To whom access to records/information may be exchanged:

_____	_____
Last name, first name	Relationship to student
_____	_____
Telephone number	Email
_____	_____
Last name, first name	Relationship to student
_____	_____
Telephone number	Email
_____	_____
Last name, first name	Relationship to student
_____	_____
Telephone number	Email

List individuals on this form ONLY if you intend to grant them the **same type** of information access. Otherwise, if you wish to provide access to different information, please complete separate forms as necessary.

Type of records/information to be provided/exchanged (and related Wheaton College offices):

- Academic (incl. but not limited to) grades, grade point average, enrollment level, course selection, academic standing (probation, dismissal): *Registrar and Academic Advising*
- Financial aid and Student account (incl. but not limited to) satisfactory academic progress for receipt of financial aid, FAFSA, award amounts, account balances, account charges, billing, and payment(s): *Student Financial Services*
- Conduct (incl. but not limited to) academic and non-academic disciplinary processes, findings, and/or sanctions: *Residence Life*
- Coordination of ongoing communication, support, care, and follow-up (i.e., care plan, support plan): *Student Wellness*
- ADA/504 accommodations (incl. but not limited to) diagnosis for accommodation needs, and psychoeducational testing (see section 2 "Additional Information" for authorization to release accommodation information): *Learning and Accessibility Services*
- Medical records (see section 2 "Additional Information" for authorization to release medical information): *Student Health Services*
- Mental health records (see section 2 "Additional Information" for authorization to release mental health information): *Student Wellness, Counseling Center, and Student Health Services*
- Other

2. Additional Information (if applicable) for ADA/504 Accommodations, Medical, or Mental Health Needs

Protected Information: If you consent to the release of any of the following information, please check all categories of information that may be disclosed pursuant to this Authorization for Release of Information.

- HIV/AIDS Testing Information or Test Results
- Genetic Testing and/or Genetic Counseling
- Psychiatric/Mental Health Information
 - Psychological Testing
 - Treatment Summary
 - Treatment or Discharge Plan
- ADA/504 Accommodations and/or Disability-Related Documentation
- Substance Abuse/Alcohol Treatment
- Other

Student Signature

Date (mm/dd/yyyy)

Parent/Guardian Signature
(if the student is under the age of 18)

Printed Name

Date (mm/dd/yyyy)

Wheaton College Staff Official Signature (Witness)

Printed Name

Date (mm/dd/yyyy)

I understand that, because this Authorization for Release of Information includes medical or mental health records as listed above, this form will only be valid for 12 months from the date of the student's signature unless revoked.

3. Your Rights and Responsibilities

Please review and then sign to authorize the disclosure of the information as indicated above.

I understand that I may revoke this authorization at any time. Any such revocation will be valid, except for the release of information that occurred prior to this authorization being revoked. I may inspect and/or copy the information sought to be used or disclosed in this authorization as permitted by applicable law or federal privacy regulations. I understand that by signing this form, I am confirming my authorization that Wheaton College office(s) and its agents may use and/or disclose the information described in this form to the person(s) and/or agency(s) named in this form. I understand that I may request a copy of this authorization after signing below.

This authorization is voluntary and I am under no obligation to sign this form and no organization/department may condition treatment, payment, enrollment, or eligibility for benefits on signing this form. I understand that refusing to sign this form does not stop disclosure of information that is otherwise permitted [by law](#) without my specific authorization, consent, or permission. I understand that in order to revoke this authorization form, *a written request* must be submitted online or to the Wheaton College office where this authorization form was signed. I understand that revocation of this authorization will not affect any disclosures or actions taken by Wheaton College before receiving the written notice of revocation. The form is available for use by students who are in communication with a Wheaton College office or employee where/when a release of information is needed. However, this form does not create a right for third parties to receive automatic communication from College officials and/or receive notice about or access to student records.

4. Certification

I understand that this authorization may be revoked/rescinded by me at any time and that I may modify this authorization through the submission of a new Authorization for Release of Information Form.

Student Signature: _____

Date: _____

Wheaton College office where this authorization form was signed: _____