OASIS PROGRAM

Mercyhurst University – The North East Campus
16 West Division Street
North East, Pennsylvania 16428
(814) 725-6250
FAX: (814) 725-6375

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I, _____, am authorizing the OASIS Program to:
(check which applies)

_____ request from
_____ release to
_____ exchange with

the following individual(s), college departments, or medical/community organizations:

_____Name

_____ Street

_____ City/State

_____ Phone number

The following privileged academic and health care information pertaining to myself may be shared by the OASIS Program with the individual/college department, or organization listed above:

_____ Academic and Educational information (e.g., Individualized Education Plan, School-based Behavior Plan, 504 Plan, Report Card, Transcript)

Please specify specific documents and relevant dates:

_____

_____

_____

_____

_____ Drug and alcohol information

_____ Mental health information

_____ Other: (specify) _____

This information is released and/or requested for the purpose of:

_____ Gathering of information to assist the OASIS Program's understanding of the student's academic and health history

_____ Coordination with other service providers

_____ Other: (specify) _____

I have read this authorization, or had it explained to me, and I understand its contents.

Date:_____

Signature:_____
(Client/Student or Legal Representative)

Print full name: _____

Address _____

City, State, Zip Code _____

If you are the **legal representative** of the person listed above, please check off the basis for your authority:

Parent of Minor _____

Power of Attorney (attach copy) _____

Guardianship Order (attach copy) _____

Other (Specify and attach copy) _____

This authorization expires on **ONE YEAR FROM DATE OF SIGNATURE**.

I understand that I have a right to revoke this authorization at any time. I may not revoke it to the extent that the OASIS Program has already relied upon it. In order to revoke this authorization, I understand that I must revoke it in writing to the OASIS Program.

I understand that information used or disclosed under this authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me by law.

A **COPY** of this authorization has been offered to the Client/Student and

Accepted _____

Not Accepted by the Client/Student _____

_____ _____
Signature of OASIS Program Representative Date