COMMUNITY COLLEGE OF ALLEGHENY COUNTY

OUR GOAL IS YOUR SUCCESS.

Supportive Services
Allegheny Campus
808 Ridge Avenue
Pittsburgh, PA 15212
Ph: 412.237.4612
Fax: 412.237.2721

Supportive Services
Boyce Campus
595 Beatty Road
Monroeville, PA 15146
Ph: 724.325.6604
Fax: 724.325.6733

Supportive Services
North Campus
8701 Perry Highway
Pittsburgh, PA 15237
Ph: 412.369.3686
Fax: 412.369.3661

Supportive Services
South Campus
1750 Clairton Rd
West Mifflin, PA 15122
Ph: 412.469.6215
Fax: 412.469.6357

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby authorize the Community College of Allegheny County's Office of Supportive Services to release any and all records and information which they may have concerning me to the person/ organization named below. It is my understanding that the information will be released in support of my enrollment as a student at the Community College of Allegheny County. I understand that this authorization is voluntary and that I may be selective in to whom and what information is disclosed. However, I am also aware that personal information relating to medical and mental health treatment may be disclosed.

Student Name: _____ID#:_____

Current Address: _____ Birth Date: _____

Home Phone: _____ Mobile Phone: _____ Email: _____

Information to be released:

- ☐ Educational/Academic
- ☐ Mental Health
- ☐ Employment/Vocational
- ☐ Medical
- ☐ Intake Documents
- ☐ Other _____

Please DO NOT disclose the following Information: _____

This information may be released for the purpose of:

- ☐ Determining appropriate academic accommodations
- ☐ Coordination of treatment
- ☐ Other (please specify)

Name and address of the person(s)/organization(s) to whom the release is to be made:

NAME			TITLE
ORGANIZATION			TYPE
ADDRESS			RELATIONSHIP TO STUDENT:
CITY	STATE	ZIP CODE	PHONE

I have been informed of the Community College of Allegheny County's Office of Supportive Services policies regarding confidentiality and the release of my personal information. I understand that I may inspect the information disclosed under this authorization and that I may receive a copy of this signed authorization form upon request. I understand that this authorization may be revoked in writing to the Office of Supportive Services at any time, except to the extent that action has already been taken in reliance on this authorization.

I hereby release the Community College of Allegheny County and its employees and agent from any liability arising from the release to the parties designated herein of the information that the Office of Supportive Services is herein authorized to release.

I understand that this authorization shall automatically expire one (1) year from the date of signature unless indicated otherwise below:

Duration of Authorization:

☐	Indefinitely until revoked by me, in writing.
☐	Date of authorization _____
☐	Other (please specify) _____

Notice to Student:
Your signature below indicates that you understand the Community College of Allegheny County's Office of Supportive Services is not a covered entity under the HIPPA Federal Privacy Regulations and is, consequently, not subject to those regulations.

_____
Printed Name of Student:

_____ _____
Student Signature: Date:

_____
Printed Name of Legal Representative*:

_____ _____
Signature of Legal Representative: Date:

* A copy of the personal representative's legal authority to act on behalf of the student is attached