Fashion Institute of Technology
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FIT-ABLE
Room A570
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Authorization to Release Medical Information for Housing Accommodation Request

I wish to request an on-campus housing accommodation at FIT due to a disability and to provide FIT with medical information to support my request. I understand that by signing this authorization form, I am agreeing to allow FIT-ABLE to seek information from my health care provider (e.g., physician, social worker, psychiatrist, etc.) identified below about my disability and the nature of the accommodation that I require.

I understand that by signing this form, I am also authorizing my health care provider listed below to provide medical information to FIT-ABLE about my disability and the nature of the accommodation that I require. As indicated on the Medical Information Form for Housing Accommodation, this may include my diagnosis, functional limitations, relevant medical tests and records, medications that I take, and a recommendation about an accommodation for me, as well as other information that my health care provider determines is relevant to my request for an accommodation.

I have identified the following health care provider to disclose medical Information to FIT-ABLE to support my request for a housing accommodation.

Name of Health Care Provider:_____
Address:_____
Phone number:_____
Email address or fax number:_____

I understand that medical information provided about me will be kept private by FIT-ABLE, in accordance with all applicable laws and regulations, and that I can request further information from FIT-ABLE about its privacy policies.

Student Name: _____ Birth Date: _____

Student Signature:_____ Date:_____

Once you have signed this form, please send this release and the Medical Information Form to your healthcare provider via mail, in-person, email, or fax.

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