Authorization for Release of Medical Information

I, ________________________________, DOB _______________, :

_____ (initial) request and authorize the following professionals to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of postsecondary planning and disability accommodation implementation to Accessibility Services/ADA Coordinator/designee:

_____ (initial) also request and authorize Accessibility Services/ADA Coordinator/designee to release pertinent medical, psychological, educational, or vocational information regarding my disability for the purpose of postsecondary planning and disability accommodation implementation to the professional/s listed below; and/or

_____ (initial) also authorize the professional/s listed below to speak with Accessibility Services/ADA Coordinator/designee about my medical, psychological, educational, and/or vocational history, treatment, diagnosis, opinions, and other related information regarding my disability for the purpose of postsecondary planning and disability accommodation.

____
Licensed Professional – Signature

____
Licensed Professional - Printed Name

____
Street, City, State, Zip Code

____
Phone # Fax#

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to Accessibility Services/ADA Coordinator. The revocation will not apply to action taken prior to that date.

Student Signature______________________________Date_____________________________

Final – 8-24-2021