AUTHORIZATION TO RELEASE / EXCHANGE CONFIDENTIAL INFORMATION

I, , authorize the Accessibility Resource Center to:

- ☐ release to:
- ☐ obtain from:
- ☐ exchange with:

The following information pertaining to myself:

- ☐ treatment summary
- ☐ history/intake
- ☐ diagnosis
- ☐ psychological test results
- ☐ psychiatric evaluation/medication history
- ☐ dates of treatment attendance
- ☐ other (specify):

for the purpose of:

- ☐ evaluation/assessment and/or coordinating treatment efforts
- ☐ providing academic accommodation
- ☐ other (specify):

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier day, condition, or event as described herein:

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

Student ID #:

Signature of Student: Date:

Signature of Witness: Date:

This form cannot be used for the release of confidential documents provided to the Accessibility Resource Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

RECORD OF AUTHORIZATION EXTENSIONS

I hereby confirm that I have received this form and agree to its extensions for an additional:

Check One:

☐ 6 months Date of extension:
☐ Other (specify):

Signature of Client: Date:

Signature of Witness: Date:

Check One:

☐ 6 months Date of extension:
☐ Other (specify):

Signature of Client: Date:

Signature of Witness: Date:

Check One:

☐ 6 months Date of extension:
☐ Other (specify):

Signature of Client: Date:

Signature of Witness: Date: