UNION UNIVERSITY

OFFICE OF DISABILITY SERVICES

RELEASE OF INFORMATION

Student Life

AUTHORIZATION TO RELEASE DISABILITY-RELATED EDUCATIONAL RECORDS

Student's Name: _____ Date of Birth: _____

Previous Name: _____ Phone #: _____

Student Union ID # or Social Security #: _____

I request and authorize the Union University Office of Disability Services to release confidential information of the above named student to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____ Email: _____

Relationship to student: _____

The nature of the information to be released is:

_____ Discussion about student meetings and progress

_____ Proof of approved accommodations for a disability while at Union University

_____ Copy of medical documentation held by Union University

_____ Other (please explain):

_____

_____

For transmission of records, requested information should be released by (check all that apply):

Fax _____ Email _____ Mail _____ Phone _____

Student Signature: _____ Date: _____

THIS AUTHORIZATION EXPIRES A YEAR AFTER THE STUDENT'S LAST DAY OF ENROLLMENT. IF THE STUDENT IS NO LONGER ENROLLED, THIS AUTHORIZATION EXPIRES ONE YEAR AFTER IT IS SIGNED. THE STUDENT MAY CANCEL THIS AUTHORIZATION BY WRITTEN NOTIFICATION AT ANY TIME.