DISABILITY RESOURCE CENTER

1 University Circle
Macomb, IL 61455-1390
Telephone: 309-298-2512
Fax: 309-298-2361

RELEASE/DISCLOSURE AUTHORIZATION FORM

I authorize **the Disability Resource Center** to **obtain** or **release** written or oral information about:

Student's name:______________________________ _______________________________________ ________
Last First MI

Regarding: ☐ Evaluation ☐ Services ☐ Testing

To/From:____
Name of Person or Agency

____
Person or Agency Address (Street, Apt. #, P.O. Box)

______________________________ ______________________________ ______________
City State Zip

______________________________ ____
Telephone Number Fax Number

We request this disclosure

- ☐ for obtaining documentation of a disability (visual, hearing, medical, psychological)
- ☐ for facilitating continuing education services
- ☐ for coordinating services
- ☐ for other reasons (specify)____

I understand information obtained or released by the Disability Resource Center will be used to assist with the provision of accommodations or services, and I give consent for disclosure of this information valid until:

____________________ __________________ ___________________
Month Day Year

X____**X**____________________________
Student's Signature Date

X____**X**____________________________
Witness' Signature Date

****Notice to receiving agency or person** - Do not re-disclose this information.**