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.**