EXCHANGE OR RELEASE OF INFORMATION WITH NON-SU EMPLOYEES

I, ____________________________________________, give my permission for the:

1. **RELEASE** of confidential information **FROM** Disabilities Services **TO** the following indicated person(s) or office(s).

2. **EXCHANGE** of confidential information **BETWEEN** Disabilities Services **AND** the indicated person(s) or office(s).

Please initial one or more:

____ Parent(s): (Name) ____________________________________________

____ Other Person(s)/Office/Department/Agency (off campus) _________________

If you want to **RESTRICT** the information, please list the **SPECIFIC** information you want released; otherwise, the Disabilities Services Director or the Disabilities Specialist will use his or her professional judgment.

__________________________________________________________

__________________________________________________________

This authorization may be revoked by me **at any time** unless the requested information has already been released. In any event, this consent will expire upon my graduation, or upon the following conditions or events:

__________________________________________________________

__________________________________________________________

__________________________________________________________

__________________________________________________________

Signature of student ___________________ Date ___________________