

Release of Information

I, _____, hereby voluntarily authorize:

California Polytechnic State University
Disability Resource Center
Student Services Building 124, Room 119, San Luis Obispo, CA 93407-0205
Office: (805) 756-1395 Voice or TDD FAX (805) 756-5451

To exchange information with:

(Name) _____

(Agency) _____

(Address) _____

(City/State) _____

(Phone) _____

(FAX) _____

From the records of:

(Student's Name) _____

(Student's ID #) _____

(Address) _____

(City/State) _____

(Phone) _____

This release is for the purpose of (indicate the specific reason):

This information is intended for use by the above named recipient only. I am aware that the records released may contain information relating to diagnoses pertaining to a disability. This authorization will expire exactly one year from the date below or on _____.

I have the right to receive a copy of this authorization. I may revoke this authorization at any time in writing. I understand that information used or disclosed under this authorization may be subject to redisclosure by the recipient pending state and federal regulations. I understand that I may be charged for copies provided. Incomplete information may cause a delay.

Signature of Student

Printed name

Date

Signature of Parent/Guardian
(For non-enrolled minors under age 18)

Printed name

Date