3201 Campus Drive, LRC 229C
Klamath Falls, OR 97601
541-851-5227 Phone
541-885-1126 Fax

Disability Services : Authorization for Release of Confidential information

Disability Services is committed to keeping sensitive disability-related information confidential, and information will be released only on a need-to-know basis. Any documentation of a disability that originated from another provider will not be re-disclosed without your written consent.

Student Name: _____ ID Number: _____

I authorize Disability Services to release information to:

First Name		Last Name		Relationship	
Phone Number		Address			
First Name		Last Name		Relationship	
Phone Number		Address			
First Name		Last Name		Relationship	
Phone Number		Address			

I authorize Disability Services to release information to the following offices/services:

- ☐ Peer Consulting
- ☐ The ROCK
- ☐ Tech Opportunities Program (TOP)
- ☐ Other: _____

The information to be disclosed includes: _____

_____

_____

This information is necessary for the following purposes:

- ☐ Assistance in personal/academic advising/counseling
- ☐ Other: _____

This release will remain in effect until: _____
I may revoke this release, in writing, at any time, except to the extent that action has already been taken.

Student Signature: _____ **Date:** _____