AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION FROM UW-COLLEGES STUDENT ACCESSIBILTY SERVICES

STUDENT NAME: ____ CAMPUS: ___________

STREET ADDRESS: ____

CITY: ___________________________________ STATE: ______________ ZIP: ________________

PHONE: ( ) _______________________ BIRTHDATE: ___________________

I hereby authorize the University Of Wisconsin Colleges Office Of Student Accessibility Services to release of the following information (check all that apply):

- ☐ Educational Records
- ☐ Medical/Psychological Records
- ☐ Conversation/Correspondence Regarding Student
- ☐ Individual Accommodation Plan (IAP)
- ☐ Other (specify): _________________________

Information may be released to:

Name: ____

Address: ____

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Phone: ( ) ____________________ FAX: ( ) _________________________

I understand that I can submit a written statement revoking or changing this release form at any time. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under SS. HSS 92.05 and 92.06, and Wis. Stats. Sec. 146.83. This release expires one year from the date signed. Copies of this release are as valid as the original.

Student Signature: ______________________________________ Date: __________________