DISABILITY SUPPORT SERVICES

1 University Circle
Macomb, IL 61455-1390
Telephone: 309-298-2512
Fax: 309-298-2361

WESTERN ILLINOIS UNIVERSITY

RELEASE/DISCLOSURE AUTHORIZATION FORM

I authorize **Disability Support Services** 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 Disability Support Services 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.**