THE UNIVERSITY OF
ALABAMA IN HUNTSVILLE

Disability Support
Services

Authorization to Release/Exchange Confidential Information

I, ______________________________ ______________, authorize UAH Disability Support Services to
(Full legal name) (Date of birth)

- ☐ **Release to**
- ☐ **Obtain from**
- ☐ **Exchange with**

Name: ____

Street Address: ____

City: ______________________________________ State: _____ Zip:___________

Phone Number: ____

Fax Number: ____

the following information pertaining to myself:

- ☐ All pertinent information contained in my file
- ☐ Pertinent information required to arrange reasonable accommodations for my disability
- ☐ Record of attendance
- ☐ Other (please specify) ____

for the purpose of:

- ☐ Evaluation/assessment or coordination of efforts
- ☐ Family support

This authorization is valid until ______________________. I understand I may revoke my consent at any time (except to the extent that information has already been released).

_____________________________ ____________________ ___________________________

Student Signature **Date** **A#**

Notice to person/agency receiving disability information: This information has been disclosed to you from records whose confidentiality may be protected by federal and state law. If the records are so protected, you are prohibited from making any further disclosure without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. Any unauthorized disclosure of disability information is unlawful and may result in civil damages and/or criminal penalties.

Any digital or paper copy of the signed form will be legal.