

AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

Student Name: WSU ID: Date of Birth:

I hereby authorize Student Accommodations and Disability Resources at Washington State University to discuss, disclose, exchange, receive, or release my educational records and/or information, including information about me relating to disability, health, wellness and/or counseling, to or from the individual/agency listed below. This release is valid for a period of four (4) years from the date of my signature unless earlier revoked by me in writing.

Name:

Agency/ Relationship to Student:

Email address(es):

Phone: FAX:

Address:

Specific information to be communicated includes: (Please initial all that apply):

Documentation (disability, medical, psycho-educational testing, mental health)

Academic Records (IEP/504 plans)

Other (as specified):

Please read and initial:

I understand that, in compliance with the *Family and Educational Rights and Privacy Act of 1974,* Student Accommodations and Disability Resources at Washington State University is prohibited from releasing my student record information to a third party without my written authorization.

I understand that the information received by WSU will be kept confidential by WSU to

the extent allowed or required by law.

I understand I must complete a separate form for each third party.

I understand a photocopy of this document has the same authority as the original.

Student Signature: Today’s Date:

Address:

City, State, Zip:

Phone Number:

Student Accommodations Specialist:

PO Box 642322, Pullman, WA 99164-2322

509-335-3417 Fax: 509-335-8511 accommodations@wsu.edu accommodations.wsu.edu