AUTHORIZATION FOR RELEASE OF RECORDS/INFORMATION

Student Name ___________________________WSU ID# ___________Date of Birth________

I hereby authorize the Access Center 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____

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*, the Access Center 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#____

Access Advisor_____________________________________