ST. CLOUD STATE
UNIVERSITY
A tradition of excellence and opportunity

SCSU Student Accessibility Services
720 4th Avenue South
Centennial Hall 202
St. Cloud, MN 56301
320-308-4080 Fax: 320-308-5100

Authorization for Release of Information

Student Name___________________________________ ID #_____________________________

I hereby authorize: ( ) Disclose to ( ) Obtain from ( ) Exchange with

SCSU	____
Accessibility Services	____
720 4th Avenue South	____
St. Cloud, MN 56301	____

Purpose of Disclosure:
( ) Disability Documentation
( ) Transfer to another institution
( ) To coordinate support services
( ) Other

Specific Information to be Released:
( ) Medical Diagnosis ( ) Recommended Accommodations
( ) Psychological Diagnosis ( ) Psycho-Educational testing results
( ) Educational Assessment (Please note: Education Assessment – an IEP alone is not adequate documentation – please include assessment/evaluation)
( ) Other ____

May information be sent by FAX: ( ) Yes ( ) No

Information regarding this authorization:

- Each transfer of Medical Records requires a new release form signed by the student.
- This form allows exchange of Counseling/Mental Health records for ONE YEAR.
- I may revoke this consent at any time by providing the SAS office with a written statement specifically revoking this authorization.
- I will receive a copy of this authorization form upon request.
- Information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by Federal privacy regulations.

I have reviewed and understand the content of this authorization form. By signing this authorization I am confirming that it accurately reflects my wishes.

____ ____________________
Signature of Student Date