ST. OLAF COLLEGE

DISABILITY AND ACCESS

AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT NAME:_____ **DATE OF BIRTH:** _____

INFORMATION RELEASED FROM:	**INFORMATION RELEASED TO/EXCHANGED WITH:**
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

AUTORIZATION TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING:

____Psychological/psychoeducational testing

____ Progress/meeting notes

____Two-way verbal communication

____Other (please specify below)

THIS INFORMATION IS TO BE USED FOR: _____

_____

I understand that I may revoke this authorization at any time and that, in any event, this consent expires within one year of this date. This information may not be further released without specific consent of the above-named person who is making the disclosure. A photocopy/fax of this authorization will be treated in the same manner as the original.

SIGNED: _____ **DATE:** _____

WITNESS:_____ **DATE:** _____