Academic Success and Accessibility

AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____ DOB: _____ ID #: _____

I hereby authorize the disclosure/exchange of MEDICAL, PSYCHIATRIC, PSYCHOLOGICAL and/or EDUCATIONAL TESTING RECORDS/INFORMATION by and between:

University of Redlands
Academic Success and Accessibility
ASA@redlands.edu
1200 East Colton Ave, P.O. Box 3080
Redlands, CA 92373-0999
Telephone: (909) 748-8069
Fax: (909) 335-5296

AND _____

_____

_____

This Authorization/Consent is subject to revocation by the undersigned at any time except to the extent that action has been taken under this Consent, and if not earlier revoked, it shall terminate without revocation on: _____
(not to exceed one year)

Information to be released: _____

_____

Information released for the purpose of: _____

_____

I understand that I have a right to receive a copy of this Authorization/Consent if I so request.

_____ _____
Signature (Client/Patient, Parent, Guardian, or Authorized representative) **Date**

_____ _____
Witness **Date**