I, ___________________________________, DOB ______________ hereby authorize the

☐ release ☐ two way exchange

of confidential information contained in my records by:

Person/Agency Name: ____
Address: ____
City: ____________________________ State: ____________ Zip: _____________________

☐ to ☐ between

Person/Agency Name: ____
Address: ____
City: ____________________________ State: ____________ Zip: _____________________

☐ Documentation of Learning Disability (all standard scores must be included)
☐ Documentation of Psychiatric Disability (DSM V/TR diagnoses must be included)
☐ Documentation of Medical Disabilities (ICD 9/10 diagnoses must be included)
☐ Other ____

-Release expires in one year
-I understand that I may revoke the consent to release confidential information at any time in writing. I alsounderstand that any release that has made prior to this revocation and which was made based upon this authorization shall not constitute my right to breach of confidentiality.

____ ___________________________
Student Signature Date

____ ___________________________
Parent/Guardian Signature (required if student is a minor) Date

- x Student may view the document, unless provider indicates otherwise
- x A photocopy of this document is acceptable
- x Please indicate records CONFIDENTIAL and mail to:

Office of Disability Services,

ODS 2018 Form adapted with permission from CSUSB, Services to Students with Disabilities.