



DISABILITY SERVICES
AUTHORIZED TO RELEASE PROFESSIONAL
CONFIDENTIAL INFORMATION

Instructions to the Client:

1. Make sure all blanks on the form are filled in before you sign below.
2. Sign this form only after a request for accommodations has been made.
3. Make sure the release of information is in your best interest.

I, _____ give my permission to the Office of Disability Services of Prairie View A&M University to receive full medical, educational, or other pertinent information from appropriate professional agencies or sources.

In addition, authorize the professional staff members of the Office of Disability Services of Prairie View A&M University to release information about me to:

(Please initial all that apply)

_____ appropriate PVAMU faculty, staff, and administrators on a need to know basis only.

_____ standardized testing agents (e.g., for the TASP, GRE, LSAT, etc.) As needed.

_____ other institutions of higher learning as needed and specific below:

_____ other off-campus professional as needed and specified below:

_____ other:

The primary purpose of this release is to help ensure my receiving course, or other ADA approved accommodations.

It will be in effect during the duration of my enrollment at Prairie View A&M University;

However I may withdraw my approval for release of information at any time.

RESTRICTIONS:

As with our own records, any information you authorize other professionals to release to this facility will be held strictly confidential.

Print name: _____ **SID or UIN#:** _____

Signature: _____ **Date:** _____

Signature of Witness: _____ **Date:** _____

Please do not leave any documentation with this office that you do not want released to other professionals.