CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO
Services to Students with Disabilities

RESPECT • ABILITY • ACCESS • DIGNITY

Voluntary Release of Confidential Information

I, _____ DOB _____

(former name used _____) hereby authorize the

☐ release ☐ two-way exchange

of confidential information contained in my records by:

Person/Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

☐ to ☐ tween

Person/Agency: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

☐ **Documentation of learning disability**
☐ **Documentation of psychiatric disabilities**
☐ **Documentation of medical issues**
☐ **Audiology/speech/language results**
☐ **Housing Accommodation**
☐ **Other:** _____

- This release does not expire until revoked.
- I understand that I may revoke this consent to release information at any time in writing to ssd@csusb.edu. I also understand that any release which has been made prior to my revocation and which was made based upon this authorization shall not constitute a breach of my right to confidentiality.

Student Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(required if student is a minor)

- Unless the provider indicates otherwise, documentation may be viewed by the student.
- A photocopy of this consent is deemed acceptable.
- Please mark records **CONFIDENTIAL** and mail/fax/email to: California State University, San Bernardino

Services to Students with Disabilities 5500
University Parkway, UH-183
San Bernardino , CA 92407-2397
Phone: 909.537.5238 ● Fax:
909.537.7090 Email: ssd@csusb.edu