Voluntary Authorization for Release of Confidential Information
Services to Students with Disabilities
CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO

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: _____

( ) to ( ) between

Person/Agency: _____

Address: _____

City: _____ State: _____ Zip: _____

- ☐ **Documentation of learning disability** ~All standard scores must be included
- ☐ **Documentation of psychiatric disabilities** ~DSM-IV/TR diagnoses must be included
- ☐ **Documentation of medical disabilities** ~ICD-9/10 diagnoses must be included
- ☐ **Audiology / speech / language results**
- ☐ **Other:** _____

- This release will expire in 1 year.
- I understand that I may revoke this consent to release information at any time in writing. 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 (required if student is a minor) Date

- 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 to: California State University, San Bernardino
  Services to Students with Disabilities
  5500 University Parkway, UH-183
  San Bernardino, California 92407-2397
  Phone: 909.537.5238 ~ Fax: 909.537.7090

White – Agency Canary – SSD Pink - Student