SIU CARBONDALE
SOUTHERN ILLINOIS UNIVERSITY
DEPARTMENT OF
DISABILITY SUPPORT SERVICES

Authorization for the Release of Information

Name _____ Date of Birth _____
Address _____ City, State, Zip _____
Student ID _____ Phone Number _____
Email _____

I hereby authorize Disability Support Services at SIU Carbondale to: ☐ Obtain Information From ☐ Release Information To

Name of Person or Agency _____
Relationship to Student _____
Address _____ City, State, Zip _____
Phone _____ Fax _____

PURPOSE OF THIS REQUEST: ☐ Document Disability ☐ Other

_____

TYPE OF RECORDS AUTHORIZED: ☐ Psychiatric/Psychological Evaluation ☐ IEP or 504 Plan
☐ Vision or Hearing Evaluation ☐ Medical/Treatment Records ☐ LD or ADD Assessment
☐ Other

_____

This authorization will expire:
◯ When the requested information has been sent/received
◯ One year from this date
◯ When I am no longer receiving services from DSS

I understand that:

- Signing this authorization is voluntary.
- I may cancel this authorization at any time by submitting a written request to Disability Support Services.
- This cancellation will not affect any disclosure that has already occurred.

Signature of Student: _____ Date: _____

Contact Information

Disability Support Services
Woody Hall 247, MC 4705
900 S. Normal Ave
Carbondale, IL 62901

P: 618-453-5738
F: 618-453-5700
VP: 618-615-4492
disabilityservices.siu.edu