



Student Disability Services

3100 Burge Hall
Iowa City, Iowa 52242-1214
319-335-1462
Fax 319-335-3973

Consent to Release of Information

Student's Name _____ Birth date _____ University ID _____

I, the undersigned, hereby understand that by signing this form I authorize the Office of Student Disability Services to obtain information from, and/or disclose information concerning the above-named individual to:

Name _____ Address _____ Phone Number _____

This information will pertain to contacts and services at the Office of Student Disability Services. It involves:

- Verbal Exchange Letter Records of Service

Other (Specify): _____

I understand the information is to be used for the following reason(s):

I understand that this authorization is voluntary and I may revoke this consent at any time by sending a written notice to Director, Office of Student Disability Services, The University of Iowa, 3100 Burge Hall, Iowa City, Iowa 52242. I understand that any release that was made prior to my revocation and was made in reliance upon this authorization shall not constitute a breach of my rights to confidentiality. I understand that I may review the disclosed information or ask questions by contacting the Director at the above address.

This authorization will expire one year from the date of signature, except as specified _____ (specify number of days or months). At that time, no express revocation shall be needed to terminate my consent.

I understand that the information to be released may include information in the following categories unless I specifically deny the release. (Please check any category **not** to be released.)

- Mental Health
 Substance Abuse
 HIV-Related Information

Signature

Date

3/8/06

Signature of Student or Legal Guardian

Date

Address

City/State/Zip Code

Relationship If Not the Student

Witness Signature