

**Release of Information – Authorization
Office of Student Disability Services**



Information is requested on: (Please print clearly)

Name: _____

Date of Birth: _____

Social Security No.: _____

Please send information to:

Office of Student Disability Services

University of the Incarnate Word

4301 Broadway, CPO #28

San Antonio, TX 78209

(Fax) 210-805-5895

I request and authorize: _____
Name of Individual and/or Organization

to release to the Office of Student Disability Services (SDS) at the University of the Incarnate Word the following information: including information regulated by 42 u.s.c., § 290 dd-3 (alcohol) and 290 ee-3 (drug abuse) and mental health information regulated by TEX CIV. STAT. ANN., Article 5561H, 5547-87 and Texas Rules of Evidence , Rule 510.

- Psycho-Educational Evaluation Diagnostic Report(s)
- Psychological Evaluation Diagnostic Report(s)
- Vocational Evaluation Diagnostic Report(s)
- Medical Diagnostic Report(s)
- Hospital Inpatient/Outpatient Records (including mental health records)
- Alcohol and Drug Treatment Reports (including dates of treatment or attendance)
- Any and all pertinent information that would be viewed as helpful in facilitating support services for this individual (**NOTE:** ARD/IEP records and/or 504 Plans are appropriate only when they accompany a complete Psycho-Educational Evaluation Diagnostic Report).

In accordance with the requirements of the federal Family Education Rights and Privacy Act (FERPA), I understand that my right to privacy includes limiting access to all my reports and records pertaining to the provision of services and accommodations. I also understand that I may authorize other people to have access to my materials on file in the Office of Student Disability Services.

Student Signature

Date

SDS Director or Academic Counselor Signature

Date