COUNSELING AND STUDENT
ACCESSIBILITY SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

Semester______________________________

Student name_________________________________ RAM ID__________________________

Local address____

City_____________________________ State____ ZIP__________

Cell phone__________________________ Home phone___________________________

Student Email____

My signature below authorizes Albany State University Counseling and Student Accessibility Services and other relevant agency or provider to release/verify pertinent information regarding my identity or condition.

I understand that this document and exchange of information will be kept confidential and will not be released to a third party.

Authorization expiration date: ____________________________

Student signature____Date____________________

Witness signature____________________________________ Date____________________

COUNSELING AND STUDENT
ACCESSIBILITY SERVICES

HEALTHCARE PROVIDER INFORMATION SHEET

Name of provider ____

Street address____

City_________________________________ State_____ Zip__________

Phone number______________________________ Fax number________________________________

Name of provider ____

Street address____

City_________________________________ State_____ Zip__________

Phone number__________________________ Fax number________________________________