Albany State University Counseling and Student Disability Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Semester______________________________

Student name____ RAM ID__________________________

Local address____ City_____________________________

State____ ZIP__________

Cell phone____ Home phone______________________

Email____

My signature below authorizes Albany State University Counseling and Student Disability 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____________________

Albany State University Counseling and Student Disability 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__________________________________