**Consent to Release Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Muskingum ID: |  |
| Date of Birth: |   | Phone: |  |
| Address: |  | Email: |  |
| City: |  | State: |  | Zip: |  |

**Check all that apply:**

[ ]  I authorize the following location to share my disability documentation with the Disability Education Office/PLUS Program at Muskingum University:

[ ]  I authorizeDisability Education Office/PLUS Program at Muskingum University to coordinate services with the following location:

|  |  |  |  |
| --- | --- | --- | --- |
| Agency/School Name: |  | Specific party if applicable: |  |
| Address: |   |
| City: |  | State: |  | Zip: |  |
| Phone: |  | Fax: |  |

**I give my specific authorization of all relevant records EXCEPT the following:**

[ ]  Medical records, reports, and assessment information

[ ]  Psychological/Psychiatric records

[ ]  Vocational evaluations and reports

[ ]  Educational records (Psychoeducational testing, ETR, MFE, 504, IEP, etc.)

[ ]  Accommodation Information

[ ]  Other (specify): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that my disability documentation may contain information regarding my diagnosis and treatment. I am aware that my confidential disability documentation may be sent and received electronically.

I understand that this authorization may be revoked by me at any time, provided that I do so in writing and submit it to the Disability Education Office/PLUS Program. Authorization will expire in 12 months from the date of my signature unless otherwise specified. Expiration date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| Signature: |  | Date: |  |

**Information can be sent via email to** **deo@muskingum.edu** **or** **plus@muskingum.edu** **or via fax to 740-826-8285.**