



Disability Resource Center  
 Division of Student Affairs  
 Clark Howell Hall  
 The University of Georgia  
 Athens, GA 30602  
 706-542-8719

Name: \_\_\_\_\_

DOB: \_\_\_\_\_ Last 4 SSN#: \_\_\_\_\_

UGA ID: \_\_\_\_\_

### Authorization for Release of Information

I hereby request and authorize the Disability Resource Center to release pertinent medical, psychological, educational, and/or vocational information regarding my disability to the following:

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Name

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City, State, zip code

\_\_\_\_\_  
 City, State, zip code

\_\_\_\_\_  
 Phone#      Fax#

\_\_\_\_\_  
 Phone #      Fax#

A photocopy or fax of this authorization shall be as valid as the original document. I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of the Disability Resource Center. The revocation will not apply to action taken prior to that date.

\_\_\_\_\_  
 Date signed

\_\_\_\_\_  
 Signature of Student or Legal Guardian

\_\_\_\_\_  
 Date signed

\_\_\_\_\_  
 Witness Signature

NOTE TO PARTY RECEIVING INFORMATION: This information has been disclosed to you from records whose confidentiality is protected by federal and/or state laws, including without limitations, the Health Insurance Portability and Accountability Act of 1996 and the Family Educational Rights and Privacy Act. Federal Regulations prohibit you from making further disclosure of information without specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations.