Office of Disability Services
La Sierra University
Voluntary Authorization for Release of Confidential Information

I, _____, DOB _____ hereby authorize the

☐ release ☐ two way exchange

of confidential information contained in my records by:

Person/Agency Name: _____
Address: _____
City: _____ State: _____ Zip: _____

☐ to ☐ between

Person/Agency Name: _____
Address: _____
City: _____ State: _____ Zip: _____

☐ Documentation of Learning Disability (all standard scores must be included)
☐ Documentation of Psychiatric Disability (DSM V/TR diagnoses must be included)
☐ Documentation of Medical Disabilities (ICD 9/10 diagnoses must be included)
☐ Other _____

-Release expires in one year
-I understand that I may revoke the consent to release confidential information at any time in writing. I also understand that any release that has made prior to this revocation and which was made based upon this authorization shall not constitute my right to breach of confidentiality.

_____ _____
Student Signature Date

_____ _____
Parent/Guardian Signature (required if student is a minor) Date

- Student may view the document, unless provider indicates otherwise
- A photocopy of this document is acceptable
- Please indicate records **CONFIDENTIAL** and mail to:

Office of Disability Services, La Sierra University
4500 University Parkway
Riverside, CA 92505
951-785-2452
ods@lasierra.edu

ODS 2018 Form adapted with permission from CSUSB, Services to Students with Disabilities.