

INFORMATION EXCHANGE AUTHORIZATION

I hereby request and authorize the following two parties to exchange information from my records:

Services for Students with Disabilities Fresno State 5200 N. Barton Ave., ML 125 Fresno, CA 93740	→	NAME OF PERSON AGENCY ORGANIZATION
	←	ADDRESS
		FAX
		PHONE EMAIL ADDRESS

This exchange of information shall be limited to the following items:

- Diagnosis Assessments Accommodations

Other: _____

I understand that this authorization becomes effective immediately and is subject to revocation by me at any time. If not earlier revoked, it shall terminate upon my graduation or exit from Fresno State.

A photocopy of this form is as valid as the original.

_____	_____
STUDENT'S SIGNATURE	STUDENT'S NAME (PLEASE PRINT)
_____	_____
DATE	DATE OF BIRTH
_____	_____
	STUDENT ID

****STOP! WITHDRAWAL CONSENT ONLY****

STUDENT WITHDRAWAL OF CONSENT FOR RELEASE OF INFORMATION

I hereby withdraw my consent for my parent, guardian, or third party as named above, to have access to services for students with disabilities records effective immediately.

_____	_____
STUDENT'S SIGNATURE	DATE