PACIFICA
GRADUATE INSTITUTE

Authorization to Release Information

Date: _____

Name: _____

Program/Track: _____ Class Year: _____

I, _____, authorize Disability Services to release information and records to and from faculty/administrative officers, my healthcare professional(s), and spouse/family member/legally appointed representative for the purpose or need for information and records to document and create reasonable accommodation plans.

The information or records sought or disclosed may include test results, assessments, diagnoses, treatment goals, treatment plans, Individual Educational Plans, and other information to document and create a reasonable accommodation plan. I understand that any information regarding my disability shall be considered confidential and will only be shared with others within the institution on a need-to-know basis.

This release will remain in effect for the duration of the student's enrollment. I understand that I may revoke this release of information privilege at any time by informing the Disability Services Coordinator. I understand that this information is desired in order to assist those who are helping with my education and request for accommodation.

Student's signature: _____

Please return this form to Disability Services

Pacifica Graduate Institute
249 Lambert Road
Carpinteria CA 93013
(805) 565-1932 Fax