



Student Accessibility Services

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Form 2

STUDENT NAME: _____ CAMPUS: _____

ADDRESS: _____

City State Zip

BIRTHDATE: _____ PHONE: () _____

SSN (optional): _____

I hereby authorize the University Of Wisconsin Colleges Office Of Student Accessibility Services to release of the following information (check all that applies):

- Apple Educational Records
Apple Medical/Psychological Records
Apple Conversation/Correspondence Regarding Student
Apple Other (specify): _____

Information may be released to:

Name: _____

Address: _____

City State Zip

Phone: () _____ FAX: () _____

I understand that I can submit a written statement revoking or changing this release form at any time. I understand that I have the right to inspect and receive a copy of the material to be disclosed as required under SS. HSS 92.05 and 92.06, and Wis. Stats. Sec. 146.83. This release expires one year from the date it is signed. (Copies of this release are as valid as the original.)

Student Signature: _____ Date: _____

Form 2 - Rev. 3/2008