



SIUE DISABILITY SUPPORT SERVICES

Consent for Release of Confidential Information

Consent is hereby given to disclose the information and copies of record specified below of

(Name of Student)

Info to be released: _____

From/to: Southern Illinois University Edwardsville
Disability Support Services
Box 1611, Edwardsville IL 62026
Phone: 618/650-3726 Fax: 618/650-5691

From/to: _____
(Name of agency/professional person)

(Address)

(Phone) (Fax)

Signature of consenting person

Date

Signature of witness

Date