SOUTHERN ILLINOIS UNIVERSITY
EDWARDSVILLE

ACCESS Consent for Release of Confidential Information

Section 1: Student Information and Authorization

Student Name: _____

Student 800#: _____ D.O.B.: _____

*I authorize Accessible Campus Community & Equitable Student Support (ACCESS) at SIUE to **obtain,** or **release** written or oral information regarding:*

☐ Evaluation ☐ Services ☐ Testing

Section 2: To/From:

Name of Person or Agency: _____

Person or Agency Address (Street, Apt. #, P.O. Box) _____

City: _____ State: _____ Zip: _____

Telephone Number: _____ Fax Number: _____

We request this disclosure:

☐ for obtaining documentation of a disability (visual, hearing, medical, psychological)

☐ for facilitating continuing education services for coordinating services

☐ for other reasons (specify)_____

I understand information obtained or released by Accessible Campus Community & Equitable Student Support (ACCESS) at Southern Illinois University Edwardsville will be used to assist with the provision of accommodations or services. This consent form will expire one (1) year from the date of my signature below and may not be used after that date.

Student Signature: _____Date: _____

Witness' Signature: _____Date: _____

Accessible Campus Community & Equitable Student Support (ACCESS)
t 618.650.3726 **w** siue.edu/access
a Student Success Center, Room 1203, Campus Box 1611, Edwardsville, IL 62026-1611