UNIVERSITY OF ALASKA SOUTHEAST

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UAS Disability Services

Permission to Release Information

Name: __________________________DOB:_____________ I.D. #_________________

Address: ____

Phone Number: _______________________E-Mail: _______________________________

- I hereby request the following information:
  - Counseling Records
  - Counseling Attendance
  - Counseling Progress
  - Verification of Documented Disability
  - Nature of Disability
  - Accommodations needed for Disability
  - Academic Consideration and Needs
  - Other____

- Be shared, either verbally or in writing with the following individuals or departments:
  - UAS Counseling
  - UAS Faculty
  - UAS Advisors
  - Learning Center Staff
  - Egan Library
  - IT Help Desk
  - UAS Housing Staff
  - UAS Facilities Staff
  - UAS Health Services
  - Other UAS Department or Individual____
  - Representatives of DVR/TVR
  - Community agencies or private providers of medical, mental health, educational or support services:____
  - Other:____

For the purpose of:

____

Signature of Student or Guardian: ____

Signature of Witness: ____

Date: _______________**This permission to release information automatically expires one year from the signing date.**

The signer may revoke permission to release information in whole or part at any time by contacting the Disability Services office at UAS.