



DISABILITY SUPPORT SERVICES
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Sitka, AK 99835
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(907) 747-7793 Fax
sitka.dss@uas.alaska.edu

AUTHORIZATION TO RELEASE INFORMATION

UNIVERSITY OF ALASKA SOUTHEAST recognizes the rights of all individuals to confidentiality of information included in any and all personal records and for professional records maintained by an agency providing treatment services to that individual.

UNIVERSITY OF ALASKA SOUTHEAST also recognizes the rights of students to privacy of students records as required by the Family Educational Rights and Privacy Act of 1974 which states that parents of students under 18 years of age and students over 18 years or attending postsecondary schools must provide a signed release of information prior to the release of that information from their records.

I, the undersigned, fully understand the right of privacy of records and herein give my permission to:

Two horizontal lines for signature.

To release information concerning:

Two horizontal lines for subject of release.

From my records to the following person: Christopher Washko, Disability Support Services Coordinator, UNIVERSITY OF ALASKA SOUTHEAST, for the sole purpose of establishing eligibility for services and/or academic accommodations. Information will not be released to any third parties.

I grant permission for PWSCC DSS to release my grades to DVR each semester if requested by DVR counselor?

Yes No

STUDENT NAME:

ADDRESS:

BIRTHDATE:

STUDENT ID# or SSN:

I UNDERSTAND THAT IT IS MY RESPONSIBILITY to supply appropriate documentation to establish my eligibility for services and/or academic accommodations and that if the information obtained through this release is not sufficient, it will be my responsibility to supply additional documentation as needed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that once the above information is disclosed to DSS at PWSCC, it will not be subject to re-disclosure by DSS to another entity without my expressed authorization in a separate release request.

Signature of Student (or Parent)

Date