INFORMATION RELEASE AUTHORIZATION

I, Student Name ________________________ Social Security Number ____________ Birthdate __________

Authorize ___________________________ or its director, designee, or records hospital, clinic, agency, school department, to release information contained in my records to the individual or organization listed below:

1. Name of organization to whom disclosure is to be made:

   Academic Support Center
   Spring Arbor University
   106 E. Main Street , St. 34
   Spring Arbor, MI 49283

2. ______Medical documentation of physical or emotional illness/condition

   ______Psychological tests ______Vision screening tests

   ______Audiogram ______IEP Report

   ______Academic records

3. The purpose and need for such disclosure:

   ______Establish eligibility for support services to accommodate a disability

   ______Determine type of services or accommodation needed

4. The consent expires upon the following date unless expressly revoked by me prior to this date: ___________________________.

   This information is required in order for the individual to receive academic accommodation. It is maintained in the Academic Support Center and is confidential. This information does not become part of the student's permanent college record and is destroyed after a limited time.

   Client's signature_______________________________ Date________________

   Staff requesting information:
   Manda Kelly, Director of Academic Support Center

Manda Kelly
Director of Academic Support Center
Spring Arbor University
Spring Arbor Mi. 49283
517-750-6479 ext. 1479
Fax: 833-487-1058