

Central Michigan University (CMU)

Student Disability Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____

CMU ID # _____

I hereby authorize Student Disability Services, Central Michigan University, 120 Park Library, Mount Pleasant MI 48859 to :

_____ Send	Type of
_____ Receive	Information
<u> X </u> Both send and receive	Requested _____

pertinent diagnostic and/or treatment information about me with:

Name of Professional _____

Agency or Office _____

Address _____

I understand that this information is essential to my academic progress at CMU. I further understand that this information is confidential, may also be protected by the physician-patient privilege, psychologist-patient privilege, or other privilege recognized by law. Therefore, I am waiving any privilege applicable to the information and/or records identified in this Authorization for the purposes of disclosure as indicated above. I also understand that this information will be kept confidential to the extent allowed by law and used for professional purposes only. I understand that I may revoke this authorization at any time by written notice, except to the extent action has already been taken in reliance upon it.

Date _____

Signature _____

Address _____

City _____ State _____ Zip _____