# Disability Support Services

Southern Adventist University

## Voluntary Authorization for Release of Confidential Information

I, ______________________________________________, DOB ____________________________

hereby authorize the ☐ Release ☐ Two way exchange of confidential information contained in my records by:

Person/Agency Name: ______________________________________________________________

Address: _________________________________________________________________________

City: ________________________________________ State: __________ Zip: _______________

☐ To ☐ Between

Person/Agency Name: ______________________________________________________________

Address: _________________________________________________________________________

City: ________________________________________ State: __________ Zip: _______________

☐ Documentation of Learning Disability (all standard scores must be included)

☐ Documentation of Psychiatric Disability (DSM V/TR diagnoses must be included)

☐ Documentation of Medical Disabilities (ICD 9/10 diagnoses must be included)

☐ Other ____________________________________________________________________

-Release expires in one year

-I understand that I may revoke the consent to release confidential information at any time in writing. I also understand that any release that has made prior to this revocation and which was made based upon this authorization shall not constitute my right to breach of confidentiality.

____________________________________ ____________________

Student Signature Date

____________________________________ ____________________

Parent/Guardian Signature (required if student is a minor) Date

- Student may view the document, unless provider indicates otherwise
- A photocopy of this document is acceptable
- Please indicate records **CONFIDENTIAL** and mail/fax to:


Disability Support Services, Southern Adventist University

PO Box 370

Collegedale, TN 37315-0370

423-236-2544, 423-236-1838 (fax)

dss@southern.edu