Authorization for Disclosure of Personal Information

Name: _____________________________  NSHE:___________________
Rebel Mail:__________________________  Phone #: _________________

I HEARBY AUTHORIZE INFORMATION TO BE RELEASED:

FROM:
UNLV Disability Resource Center
4505 S. Maryland Parkway Box 452015
Las Vegas, NV 89154
(702) 895-0866 (P)
(702) 895-0651 (F)

TO:
Name/Agency:___________________________
Address:________________________________
_______________________________________
Phone #: _______________________________
Email Address:___________________________

☐ Allow mutual disclosure between agencies/persons listed above

Purpose for Release:_________________________________________________

Information to be Released: (Please initial each line that you authorize information to be released.)

____ Medical/Psychological Assessment  ____ Functional Limitations
____ Use of Accommodations  ____ Educational Records
____ Other (Please specify): ___________________________________________

Consent for Information to be Faxed:  ☐ Yes  ☐ No
Consent for Information to be Emailed:  ☐ Yes  ☐ No

I understand that my records may be faxed/emailed and I give my consent to transmit my records via facsimile and/or email with my understanding that confidentiality cannot be guaranteed, despite rigorous precautions to safeguard confidentiality.

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization expires one year from date of signature.

Document must be signed in the presence of a Disability Resource Center Official

Signature of Student:__________________________________________ Date:_______________
Witness to Signature:__________________________________________ Date:_______________