AUGUSTA UNIVERSITY

Testing and Disability Services
Division of Student Affairs
Phone: 706.737.1469
Fax: 706.729.2298
E-Mail: tds@augusta.edu

Authorization for Release of Information

I, _____, request and authorize the following professionals to release pertinent medical, psychological, educational, or vocational information regarding my disability to the office of Testing and Disability Services at Augusta University for the purpose of postsecondary planning and disability accommodation implementation. A photocopy or fax of this authorization shall be as valid as the original document.

Professional: _____
Street Address: _____
City, State, Zip: _____
Phone & Fax: _____

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Testing and Disability Services. The revocation will not apply to action taken prior to that date.

_____ _____
Date Signed Student Signature (required)

_____ _____
Date Signed Guardian Signature (if student is less than 18 years old)

- Upon leaving the University, it is your responsibility to request your documentation to be returned to you. All documentation will be purged five years after the last date of enrollment.