DISABILITY SERVICES
SEATTLE UNIVERSITY
901 12th Ave, Box 222000
Seattle, Washington 98122
(206) 296-5740

EXCHANGE OR RELEASE OF INFORMATION WITH NON-SU EMPLOYEES

I, _____, give my permission for the:

_____1. **RELEASE** of confidential information **FROM** Disabilities Services **TO** the following indicated person(s) or office(s).

_____2. **EXCHANGE** of confidential information **BETWEEN** Disabilities Services **AND** the indicated person(s) or office(s).

Please initial one or more:

_____ Parent(s): (Name) _____

_____ Other Person(s)/Office/Department/Agency (off campus)_____

_____

If you want to **RESTRICT** the information, please list the **SPECIFIC** information you want released; otherwise, the Disabilities Services Director or the Disabilities Specialist will use his or her professional judgment.

_____

_____

This authorization may be revoked by me at any time unless the requested information has already been released. In any event, this consent will expire upon my graduation, or upon the following conditions or events:

_____

_____

_____ _____

Signature of student *Date*