TEXAS STATE ®
DISABILITY SERVICES

Consent for Release of Confidential Information Form

Student Name:_____ Student ID:_____ Date of Birth:_____

Address:_____

Phone:_____

On-Campus Provider: ☐ Student Health Center ☐ Counseling Center

Name of On-Campus Provider:_____

Off-Campus Provider:_____

Address:_____

Phone:_____ Fax:_____

Recipient: Office of Disability Services or Other:_____

Address:_____

Phone:_____ Fax:_____

Information: All professional, medical, counseling, mental and physical health, and other information or records, confidential or otherwise pertaining to me, my evaluation, or treatment.

Reason: To assist in evaluating my request for reasonable accommodations and to ensure the appropriate provision of disability services at Texas State University.

Consent: I consent to the release of the Information to the Recipient described above for the Reason shown above. I authorize and request that the Provider furnish the Information as soon as it is practical to do so.

Release: I release and discharge the Provider and the Recipient from any claims that I may have as a result of providing the Information to the Recipient under this Consent. I understand that I cannot sue or recover anything from the Provider or Recipient as a result of providing this Information.

Revocation: I understand that I can revoke this Consent only by giving written notice of revocation to both the provider and the Office of Disability Services at Texas State University.

Student Signature: _____

Date:_____

Please return the completed form to the Office of Disability Services via in person or email at ods@txstate.edu. If you have any questions, feel free to contact our office. Thank you.

OFFICE OF DISABILITY SERVICES
601 University Drive | LBJ Student Center 5-5.1 | San Marcos, Texas 78666-4616
phone: 512.245.3451 | *fax:* 512.245.3452 | WWW.ODS.TXSTATE.EDU
This letter is an electronic communication from Texas State University.