

Permission to Release Information

The Office of Disability Services (DS) requires your written consent before disclosing any personal information related to your disability or record of accommodation(s) from this office. DS will not release any record for which re-disclosure is specifically prohibited. Your consent to share this information may be withdrawn in writing at any time.

Note: DS cannot guarantee that information shared pursuant to this consent will not be re-disclosed by the recipient.

I, _____ T# _____
(Print Name)

Request that the Arkansas Tech University Office of Disability Services release the following information from my record (*be specific*):

This information is to be released to:

Name

Address

City/State/Zip

Telephone Number

Signature

Fax Number

Date