



Authorization to Release Information to Arkansas Tech University Disability Services

Student Information: (Please prin	nt or type)	
Name		
Street Address		
City / State / Zip		
T#	Date of Birth Telephone	
Authorized Provider Informatio	n and Periods of Care:	
Clinic Name and Location:		
From (date) To	(date) Provider Name (i	f applicable):
Please Release Information/Re	cords that pertain to, or may impact the fo	llowing accommodation(s):
☐ Entire Patient/Client Record	Emotional Support Animal in ATU	Temporary Medical Condition (i.e.,
Entire Patient/Chefit Record	Housing (see attached ESA Provider Form)	injury/surgery dates, activity restrictions)
Accommodated Tests/Exams	☐ Housing/Living Arrangements	Class Attendance Flexibility/Absences
Accommodations/Assistance for Reading Print Materials	☐ Meal Plan Changes/Special Dietary Requirements	☐Due Date Flexibility
☐ Note-Taking Assistance	☐ Deaf and Hard of Hearing Assistance	□Other (specify):
Purpose for which the informat To assist in the determination of re Send information to:	ion will be used: easonable accommodations at Arkansas Tech U Office of Disability Services	Jniversity.
	Doc Bryan Building, Ste. 141 1605 Coliseum Drive Russellville, AR 72802 Phone: (479) 968-0302 Fax: (479) 968-0375 Email: disabilities@atu.edu	
writing at any time. I understand that this authoriz I understand that treatment by	ation automatically expires one year from the date indic my health care provider will not be conditioned on my thorize Disability Services to obtain the information req n requesting.	
Signature	Date	