DISABILITY ACCOMMODATIONS & SUPPORT SERVICES
CHANNEL ISLANDS
California State University

Disability Accommodations & Support Services
One University Drive
Camarillo, CA 93012
Arroyo 210
Phone: 805-437-3331
Fax: 805-437-8529

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student Name: _____

Date of Birth: _____ Student ID: _____

I, hereby authorize staff at Disability Accommodations & Support Services (DASS) at California State University Channel Islands (CI) to share and exchange information from my DASS records to:

Name: _____ Relationship: _____

Phone: _____ Email or FAX: _____

Address: _____

Purpose of exchange of information and disclosure: _____

Disclosure shall be limited to the following types of information:

- ☐ Appointment and testing attendance only
- ☐ Summary of accommodations
- ☐ Unrestricted communication
- ☐ Other:_____

This information will be provided in the following way(s):

☐ Written ☐ Verbal
☐ Email or FAX ☐ All of the above

I wish to limit disclosure as follows:

_____

By signing below, I acknowledge that I have read and understand this Authorization:

1. I understand that I have the right to review and receive a copy of my confidential records from DASS, including the current Authorization form. I understand that I can request a copy of this form after I sign it.
2. I understand that, unless withdrawn, this authorization will expire 365 days from the date of signature. A photocopy of this form will be considered as valid as the original.
3. I understand that I may revoke this authorization at any time by notifying DASS at the address indicated above, in writing, and this authorization will cease to be effective on the date notified except to the extent that action has already been taken in reliance upon it.
4. I fully comprehend the issues concerning privacy, confidentiality, and my right to forfeit signature of this authorization form. I understand that if I authorize disclosure of confidential information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.
5. I realize that my eligibility for services is not conditional upon my compliance with authorizing this form.

_____ _____

Signature of student OR legal guardian/authorized person Date

Rev. 9/15/17