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*