ST. OLAF COLLEGE

DISABILITY AND ACCESS (DAC)

AUTHORIZATION FOR RELEASE OF INFORMATION

STUDENT NAME:_____ **DATE OF BIRTH:**_____

INFORMATION RELEASED FROM:	**INFORMATION RELEASED TO/EXCHANGED WITH:**
Name:	St. Olaf College Access Specialist
Address:	1520 St. Olaf Avenue
	Northfield, MN 55057
Phone:	Phone: 507-786-3288
Fax:	Fax: 507-786-3923

AUTHORIZATION TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING:

____ Psychological/psychoeducational testing

____ Progress/meeting notes

____Two-way verbal communication

____Other _____

_____

THIS INFORMATION IS TO BE USED FOR: _____

_____

I understand that I may revoke this authorization at any time and that, in any event, this consent expires within one year of this date. This information may not be further released without specific consent of the above-named person who is making the disclosure. A photocopy/fax of this authorization will be treated in the same manner as the original.

SIGNED: _____ **DATE:**_____