TEXAS STATE®
DISABILITY SERVICES

Consent for Release of Confidential Information

Student Name: _____

On-Campus Provider: ☐ Student Health Center ☐ Counseling Center

Name of On-Campus Doctor or Counselor: _____

Off-Campus Provider: _____

Phone: _____ Fax: _____

Address: _____

Recipient: Office of Disability Services or Other: _____

Phone: _____ Fax: _____

Address: _____

Information: All professional, medical, counseling, mental and physical health, and other information or records, confidential or otherwise pertaining to me, my evaluation, or treatment.

Reason: To assist in evaluating my request for reasonable accommodations and to ensure the appropriate provision of disability services at Texas State University.

Consent: I consent to the release of the Information to the Recipient described above for the Reason shown above. I authorize and request that the Provider furnish the Information as soon as it is practical to do so.

Release: I release and discharge the Provider and the Recipient from any claims that I may have as a result of providing the Information to the Recipient under this Consent. I understand that I cannot sue or recover anything from the Provider or Recipient as a result of providing this Information.

Revocation: I understand that I can revoke this Consent only by giving written notice of revocation to both the Provider and the Office of Disability Services at Texas State University

_____ _____
Signature Date

_____ _____
Address City, State, Zip

_____ _____
Phone Date of Birth

OFFICE OF DISABILITY SERVICES
601 University Drive | LBJ Student Center 5-5.1 | San Marcos, Texas 78666-4616
phone: 512.245.3451 | *fax:* 512.2453452 | WWW.TXSTATE.EDU
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