

Authorization for Release of Information

PLEASE PROVIDE THE FOLLOWING INFORMATION:

NAME(S):	
RELATIONSHIP TO STUDENT:	ORGANIZATION AFFILIATION:
EMAIL ADDRESS:	
PHONE NUMBER:	FAX NUMBER:

I, the student named (and signing) below, hereby authorize UNI Student Accessibility Services (SAS) and/or University Housing & Dining (UHD) to release and/or exchange any and all information related to my disability SAS and/or UHD file(s) at the University of Northern Iowa to/from the entity and/or person listed above.

I hereby authorize the above listed entity and/or person to release to SAS and/or UHD all educational, medical and/or psychological records concerning my disability in relation to:

- 1) meeting and performing the academic and technical standards requisite to an education program, course, or activity; and/or
- 2) equal access to educational and campus experience opportunities where there are barriers caused by a disability; and/or
- 3) equal access to housing and dining where there are barriers caused by a disability.

I understand that education record information and other records and information reflected in this Authorization for Release of Information are protected by the federal Family Educational Rights and Privacy Act of 1974 and other laws and, without my written permission, this information or these records will not be released.

This consent remains effective until (specific date or withdrawn) _____ from UNI. I understand that I may revoke my consent at any time by sending or delivering written notice to the following address:

Student Accessibility Services
118 Gilchrist Hall
University of Northern Iowa
Cedar Falls, IA 50614-0010

Permission is hereby granted:

Student ID#

Date

Student Name (Printed)

Student Signature