Request of Information – Authorization
Office of Student Disability Services

Information is requested on: (Please print clearly)

Name: ___________________________________

Date of Birth: ______________________________

Please send information to:

Office of Student Disability Services
University of the Incarnate Word
4301 Broadway, CPO #295
San Antonio, TX 78209
(Fax) 210-829-3997

I request and authorize: ____
Name of Individual and/or Organization

to release to the Office of Student Disability Services (SDS) at the University of the Incarnate Word the following information: including information regulated by 42 u.s.c., § 290 dd-3 (alcohol) and 290 ee-3 (drug abuse) and mental health information regulated by TEX CIV. STAT. ANN., Article 5561H, 5547-87 and Texas Rules of Evidence , Rule 510.

[ ] Psycho-Educational Evaluation Diagnostic Report(s)
[ ] Psychological Evaluation Diagnostic Report(s)
[ ] Vocational Evaluation Diagnostic Report(s)
[ ] Medical Diagnostic Report(s)
[ ] Hospital Inpatient/Outpatient Records (including mental health records)
[ ] Alcohol and Drug Treatment Reports (including dates of treatment or attendance)
[ ] Any and all pertinent information that would be viewed as helpful in facilitating support services for this individual

In accordance with the requirements of the federal Family Education Rights and Privacy Act (FERPA), I understand that my right to privacy includes limiting access to all my reports and records pertaining to the provision of services and accommodations. I also understand that I may authorize other people to have access to my materials on file in the Office of Student Disability Services.

____ ______________________________

Student Signature **Date**

____ ______________________________

SDS Representative Date