DISABILITY SERVICES
RELEASE OF INFORMATION

PERMISSION IS HEREBY GIVEN TO:

Disability Services
James Madison University
Student Success Center, Suite 1202
MSC 1009
Harrisonburg, VA 22807

TO RELEASE INFORMATION TO AND EXCHANGE INFORMATION WITH: ___________________________________

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(Name, Address and Phone # of individual or organization that will be receiving information)

REGARDING: ______________________________ ______________________________

(Name of Client) **(Date of Birth**

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(Address of Client)

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(Phone #)

NATURE OF THE INFORMATION TO BE DISCLOSED: _________________________

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I understand that my consent to release this information will expire in 90 days or (___________), not to exceed one year. I understand that I may withdraw this consent in writing at any time.

________________________________ ________________________________

(Client's Signature) **(Date)** **(Guardian's Signature)** **(Date)**

____

(Witness' Signature) **(Date)**

MSC 1009
Student Success Center
Suite 1202
Harrisonburg, VA 22807
540 . 568 . 6705 Voice/TDD
540 . 568 . 7099 Fax