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
Administration Building, Suite 51
San Antonio, TX 78209
Phone: (210) 829-3997
Fax: (210) 283-6329

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 (**NOTE:** ARD/IEP records and/or 504 Plans are appropriate only when they accompany a complete Psycho-Educational Evaluation Diagnostic Report).

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 Director or Coordinator Signature Date

___ Moisés J. Torrescano, Director of Student Disability Services
___ Michelle C. Beasley, Coordinator of Student Disability Services