



RELEASE OF CONFIDENTIAL INFORMATION To Agency or Individual

Campus (Please check one):

- West Haven Campus (West Haven, CT) Tuscany Campus (Prato, Italy) Lyme Campus (Old Lyme, CT)
 New London Campus (New London, CT) California Campus (San Francisco, CA)
 New Mexico Campus (Albuquerque, NM)

I, _____, authorize the Accessibility Resources Center of the university of New Haven to release information about me to the following person(s) or agency.

Name of Organization/Individual(s) _____

Title _____

Address _____

City, State, Zip _____

Phone Number _____ **Fax Number** _____

The information to be released from my records is as follows: Documentation of my disability including, but not limited to, diagnosis and remediation.

I understand that this information shall remain strictly confidential and shall not be further relayed in any way to any other person or agency without an additional written authorization by me.

By signing this Release of confidential Information, I release the staff of Accessibility Resources Center, the University of New Haven and its employees, and the person(s) or agency named above from any liability resulting from the releases of the information. Furthermore, I understand that I may withdraw this authorization at any time prior to the release of above information. This authorizations, if not withdrawn, is valid until or until canceled by me in written. This release form has been read/reviewed with me and I understand its content.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____