Authorization for Disclosure of Personal Information

Name:_____ NSHE:_____

Rebel Mail:_____ Phone #: _____

I HEARBY AUTHORIZE INFORMATION TO BE RELEASED :

FROM:
UNLV Disability Resource Center
4505 S. Maryland Parkway Box 452015
Las Vegas, NV 89154
(702) 895-0866 (P)
(702) 895-0651 (F)

TO:
Name/Agency:_____
Address:_____
_____
Phone #:_____
Email Address:_____

Allow mutual disclosure between agencies/persons listed above

Purpose for Release:_____

Information to be Released: (Please initial each line that you authorize information to be released.)

____ Medical/Psychological Assessment ____ Functional Limitations

____Use of Accommodations ____ Educational Records

____ Other (Please specifiy): _____

Consent for Information to be Faxed: ☐ Yes ☐ No

Consent for Information to be Emailed: ☐ Yes ☐ No

I understand that my records may be faxed/emailed and I give my consent to transmit my records via facsimile and/or email with my understanding that confidentiality cannot be guaranteed, despite rigorous precautions to safeguard confidentiality.

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization ***expires one year from date of signature.***