Langston University
Office of Student Disabilities Services
P. O. Box 1500
Langston, Oklahoma 73050

Authorization for Release of Confidential Information

Date: _____

I hereby authorize _____ to release _____obtain information:

_____ Verbal case information _____ Written case information

From: _____

Name & Address of person/agency:

Specific information to be released, including specific test results:

This information is requested for the following purpose:

About your confidential records:

You understand that your records are protected under a number of federal and state confidentiality regulations and cannot be disclosed without your written consent unless otherwise provided for in state and federal regulations. You also understand that you may revoke this consent by writing a request at any time except to the extent that action has been taken in reliance on it (e.g., information has been sent or received prior to your revocation, etc.) and that in any event this consent expires automatically six months from the date of signature.

You do not authorize further release to any other party. You further understand that the University's Counseling Service (Disability Services) and its staff, employees, coordinators, and directors cannot be responsible for confidentiality of information disclosed after said information has been released pursuant to this authorization, and you hereby release the University's Counseling Services (Disability Services) from any liability arising from such disclosure.

AUTHORIZED BY: _____

Signature Witness _____

Printed/Typed Name _____