



FRANCISCAN UNIVERSITY OF STEUBENVILLE

The Office of Student Success
Egan Hall, Room 105
Phone: 740-284-5263 / Fax: 740-284-7095

***** CONFIDENTIAL *****

CONSENT AND AUTHORIZATION TO RELEASE INFORMATION FROM SASS TO PROFESSIONALS

Pursuant to Federal and State Guidelines concerning my right to confidentiality and privileged communication; I _____ hereby authorize The Office of Student Success services to release the following information from my file:

- _____ Diagnosis (*generally used for physical/medical disabilities and/or conditions*)
- _____ Psych-Educational/Neuropsychological Evaluations (*ADHD and learning disabilities*)
- _____ Psychological Evaluation
- _____ History of accommodations used while at Franciscan University of Steubenville
- _____ Other: _____

Purpose of disclosure: _____

The information is to be provided to:

Person or Organization _____

Address _____

City, State, Zip _____

Phone Number _____ Fax Number _____ Email _____

Method of providing information (circle one): Mail Fax Phone Email

I understand this authorization for confidential information applies only to the individual named above and only for the purpose stated above on the scheduled date and time and does not permit the release of information concerning me to any other individual or at any other time to the individual named above. In addition, I understand I may revoke this consent to release information at any time, but recognize that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

A photocopy or fax of this authorization shall be considered as effective and valid as the original.

Print Name: _____

Signature: _____

Student ID#: _____

Date of Birth: _____

OSS Staff or Witness

Date