

OSS Staff or Witness

The Office of Student Sucess Egan Hall, Room 105

Phone: 740-284-5263 / Fax: 740-284-7095

*** CONFIDENTIAL *** CONSENT AND AUTHORIZATION TO RELEASE INFORMATION FROM SASS TO PROFESSIONALS

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	Pursuant to Federal and State Guideline	es concernin	ng my right	to confidentia	ality and privileged		
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	communication; I		hereby a	uthorize The (Office of Student Suc	cess services	
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Other: Purpose of disclosure: The information is to be provided to: Person or Organization Address City, State, Zip	Psychological Evaluation						
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The information is to be provided to: Person or Organization Address City, State, Zip	Other:						
Person or Organization Address City, State, Zip	Purpose of disclosure:						
Address City, State, Zip	The information is to be provided to:						
City, State, Zip	Person or Organization						
	Address						
Phone Number Fax Number Email	City, State, Zip						
	Phone Number F	Fax Number			Email		
Method of providing information (circle one): Mail Fax Phone Email	Method of providing information (cir	cle 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 other individual or at any other time to the individual named above. In addition, I understand I may revoke this consent release information at any time, but recognize that any release made between the time I authorized it and then revoked shall not constitute a breach of my right to confidentiality.	purpose stated above on the scheduled date other individual or at any other time to the i release information at any time, but recogni	and time and individual nai ize that any r	l does not pe med above. I celease made	rmit the release In addition, I und between the tin	of information concer derstand I may revoke ne I authorized it and t	ning me to any this consent to	
A photocopy or fax of this authorization shall be considered as effective and valid as the original.	A photocopy or fax of this authorization	shall be co	nsidered as	s effective and	valid as the original		
Print Name: Signature:	Print Name:			Signature:			
Student ID#: Date of Birth:	Student ID#:			Date of Birth:			

Date