MONTANA STATE UNIVERSITY
NORTHERN
Disability Services

Authorization for Release and Exchange of Information

I, _____ do hereby authorize the release and exchange of the following information:

1. Documentation of disability and recommendations for reasonable accommodations.

2. _____

Between the following individuals and/or agencies:

Name: _____

Title: _____

Business/Agency: _____

Address: _____

City/State/Zip: _____

Phone: _____

Fax: _____

AND
Ligia Arango; Disability Services Coordinator
Montana State University—Northern
P.O. Box 7751
Havre, MT 59501
(406) 265-4133
(406) 265-3799 fax

I understand that all information released and/or exchanged is confidential and may not be released to any party other than those listed above without my written consent. I also understand that I may cancel this agreement at any time by notifying either party listed above in person or in writing.

Signature:_____ Date: _____

Name (Printed): _____

Address: _____

City/State/Zip: _____

Phone: _____

This authorization will expire two years from the date signed, unless otherwise noted here: _____