



# 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

Karen Terrell; Disability Services Coordinator  
Montana State University—Northern  
P.O. Box 7751  
Havre, MT 59501  
(406) 265-3776  
(406) 265-3519 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: \_\_\_\_\_*