

**ARKANSAS STATE UNIVERSITY**  
**OFFICE OF ACCESS & ACCOMMODATION SERVICES**  
**PO BOX 360**  
**STATE UNIVERSITY, AR 72467**  
**TELEPHONE: 870-972-3964**

DATE: \_\_\_\_\_

**STUDENT INFORMATION RELEASE FORM**

**ARKANSAS STATE UNIVERSITY**  
**ACCESS & ACCOMMODATION SERVICES**

I, hereby authorize the staff of Access & Accommodation Services at Arkansas State University to release any pertinent medical, psychological, educational or vocational information from employees of Arkansas State University, Rehabilitation Services and other public and private entities. This disclosure is to assist me in fully participating in an educational program activity. Disclosures of information will be restricted to what is necessary, relevant and verifiable.

**STUDENT'S NAME** \_\_\_\_\_

**STUDENT'S SIGNATURE** \_\_\_\_\_

**STUDENT'S SOCIAL SECURITY NUMBER** \_\_\_\_\_

**SIGNATURE OF WITNESS** \_\_\_\_\_