



The University of South Dakota.

**CENTER FOR DISABILITIES
DISABILITY SERVICES**

Release of Information Student

Name: _____

Social Security Number: _____

Date of Birth: _____

Physician or Facility:

Name: _____

Address: _____

Phone Number: _____

Fax Number: _____

I, _____, hereby grant the above mentioned physician/facility release information to or exchange information with Disability Services at The University of South Dakota in regards to my request for academic accommodations. I understand that I may revoke this consent by written or oral communications any time except to the extent that action based on this consent has already been taken. I agree that Disability Services may use electronic means to transfer information. I certify that this form has been fully explained to me and that I understand its contents.

Signed: _____ Dated: _____

Witness: _____ Dated: _____