CALIFORNIA STATE UNIVERSITY, LOS ANGELES

OFFICE FOR STUDENTS WITH DISABILITIES
Disabled Student Support Services Program

AUTHORIZATION FOR RELEASE OF STUDENT INFORMATION

Student's Name: _____ CIN:_____

Address:_____

City: _____ State: _____ Zip Code: _____

Primary Phone: (_____)_____ Email:_____

❑RELEASE 'FROM' CAL STATE L.A.

I authorize OSD at Cal State L.A. to release the following information and/or records to:

Name/Agency: _____

Address:_____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax(_____)_____

Preferred Method of Release: ❑Mail ❑Fax ❑Pick up

Primary Reason for Release: ❑*Psychological Evaluation* ❑*Disability Status for Accommodation(s)*
❑*Medical Evaluation/Verification* ❑*Other*

❑RELEASE 'TO' CAL STATE L.A.

I hereby authorize _____ (Fax)_____
(Agency/School)
to release my records/information to:

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
Office for Students with Disabilities
5151 State University Drive
Los Angeles, CA 90032
(323) 343-3140--Voice (323) 343-6429--Fax (323) 343-3139--TDD

I understand that I have the right to inspect and review these records as well as receive a copy for my records upon written request. ***Please allow at least 72 hours to process this request.***

_____ _____
Student Signature **Date**

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Date Processed:_____ **Staff Providing Information:** _____
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