OFFICE FOR STUDENTS WITH DISABILITIES

5151 State University Drive, Los Angeles, CA 90032
PH: 323-343-3140 Fax: 323-343-6429

Authorization for Release of Student Information

Student Name: _____ CIN: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

☑ RELEASE 'FROM' CAL STATE LA

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

Name/Agency: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

Preferred Method of Release: ☐ Fax ☐ Pick-Up ☐ E-mail:

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

☐ RELEASE 'TO' CAL STATE LA

I hereby authorize _____
(AGENCY/SCHOOL)

Fax: _____ Email: _____

to release my records/information to:

CALIFORNIA STATE UNIVERSITY, LOS ANGELES
Office for Students with Disabilities

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

_____ _____
Student Signature Date

OFFICE USE ONLY

_____ _____
Completed By Date Processed