Updated August 16, 2016

Release of Information

I, _____ , _____
Student's Full Name Student ID Number

Hereby authorize the Indiana University Student Advocates Office to release from my case file the following identified information:

☐ Only medical documentation provided to this office

☐ Any information from my case file

The above information may be released to the following:

Name or name of office (if applicable)

☐ Instructors

☐ Parents

☐ Other University officials

☐ Other (non IU)

I understand that I may revoke this Authorization, but must do so in writing. If revoked, it is understood by all affected parties that all information released prior to being notified of such revocation was made with my authorization.

I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by this authorization.

By signing this Authorization for Release of Information, I acknowledge that I have read and fully understand the terms and conditions of this authorization.

Student's Signature Date

Address

Telephone Number