Albany State University
Counseling and Student Disability Services

AUTHORIZATION FOR RELEASE OF INFORMATION

Semester_______________________________

Student name____ RAM ID___________________________

Local address____ City______________________________

State____ ZIP___________

Cell phone___________________________ Home phone____________________________

Email____

My signature below authorizes Albany State University Counseling and Student Disability Services and other relevant agency or provider to release/verify pertinent information regarding my identity or condition.

I understand that this document and exchange of information will be kept confidential and will not be released to a third party.

Authorization expiration date: _____________________________

Student signature____ Date____________________

Witness signature____ Date____________________

New Student Center (Green Zone) 504 College Drive Albany, GA 31705
(229) 903-3610 Main number (229) 903-3611 SDS direct (229) 430-3826 Fax

Albany State University
Counseling and Student Disability Services

HEALTHCARE PROVIDER INFORMATION SHEET

Name of provider ____

Street address____

City_________________________________ State_____ Zip__________

Phone number_________________________________ Fax number__________________________________

Name of provider ____

Street address____

City_________________________________ State_____ Zip__________

Phone number_________________________________ Fax number__________________________________