AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

I, _____, authorize The College of Idaho's Department of Accessibility and Learning Excellence to disclose information to, or receive information from (please provide individual information):

Name: _____

Address: _____

City: _____ST: _____Zip:_____

Telephone: _____Fax: _____

Nature of information being requested: _____

_____

For the purpose of a mutual exchange of information to facilitate:

_____

This consent expires upon the following date, event or condition:

_____

_____ _____

Student Signature Date