



Learning Support and Disability Services Department

**AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION**

I, \_\_\_\_\_, authorize Natalie Davison to disclose  
(Student's Name)

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:

\_\_\_\_\_  
(For such disclosure)

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

\_\_\_\_\_

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



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