



Disability Support Services
University of Maine

AUTHORIZATION TO RELEASE AND EXCHANGE INFORMATION

Name: _____ SS#: _____ - _____ - _____ DOB: ____/____/____

Please write you initials in the space provided before each statement that applies to your authorization

I authorize the information identified to be released:

_____ **FROM** Disability Support Services (DSS) to: _____
Address: _____ Phone: _____

_____ **TO** Disability Support Services (DSS) from: _____
Address: _____ Phone: _____

INFORMATION REQUESTED:

_____ Copy of my disability documentation sent to: _____

_____ Information and recommendations that will help in arranging for the provision of reasonable accommodations for me.

_____ Information concerning my use of, and the effectiveness of, those accommodations that I have requested and that have been approved by DSS.

_____ Supplemental relevant information regarding disability documentation and/or recommended accommodations.

_____ Other _____

This information is to be used to assist DSS in determining my eligibility to receive accommodations and identifying appropriate reasonable accommodations.

I understand this release expires on: _____ unless I notify DSS earlier. I understand I have the right to revoke this release at any time. I understand if I wish to revoke the release, I must do so in writing and give my written revocation to DSS. I understand the revocation will not apply to information released under this release prior to DSS receiving my written revocation.

Name (print): _____

Signature: _____ Date: _____