



Information Exchange Authorization -Third Party

I hereby request and authorize the following two parties to exchange information from my records:

Disability Programs and Resource Center

**San Francisco State University
1600 Holloway Ave.
Room. SSB 110
San Francisco, CA 94132**



Name of Person | Agency | Organization

Address

City, State, Zip

Phone, Fax or E-mail Address

Other Organization ID# (Medical Record #, etc)

This exchange of information shall be limited to the following items:

☐ Diagnosis & Functional Limitations ☐ Assessments ☐ Accommodations

☐ Other If other: _____

I understand that this authorization becomes effective immediately and is subject to revocation in writing by me at any time. If not earlier revoked, this agreement shall terminate upon my graduation or exit from San Francisco State University OR the following date if I am not a current student:

A photocopy of this form is as valid as the original.

STUDENT'S SIGNATURE

STUDENT NAME

DATE

DATE OF BIRTH

STUDENT ID#