UNIVERSITY of HAWAI'I® HILO

AUTHORIZATION TO EXCHANGE INFORMATION

This form authorizes the UH Hilo Disability Services office to release information about you to coordinate appropriate academic adjustments that you may be needing as a qualified student with a documented disability.

I (print full name) _____, (student ID number) _____

Hereby authorize the UH Hilo Disability Services office to release the information about me to the following organization(s) or individual(s).

☐ All agencies and agency staff with legitimate educational need to know.
☐ Faculty for current term of enrollment
☐ Specific faculty only (please list) _____
☐ Parents (name and phone number) _____
☐ Previous/future educational institutions
☐ Medical/counseling center
☐ Division of Vocational Rehabilitation (DVR)
☐ Licensed Physician, Therapist, Treating Medical Practitioner
☐ Other _____

This authorization includes confidential information from my records at UH Hilo Disability Services applies to records of:

☐ Medical diagnosis
☐ Diagnosis and assessments of cognitive or physical disability
☐ Personal Academic Plan
☐ Other (specify) _____

This personal information will be transmitted to the above named person and/or agency only on the condition that it will not be shared with another person and/or agency without my written consent.

I further understand appropriate documentation must be on file within the Office of Student Services, ADA/504 office to be eligible for services as a student with disability. I understand that in the case of a federal audit, my records may be opened.

I understand that I may revoke this release at any time; otherwise, this release will be continue to be in effect until the time that I am no longer enrolled at UH Hilo.

Student Signature: Date:

First Name M.I. Last Name

☐ **By checking the box, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form.**

Parent/Guardian Signature (If a Minor): Date:

First Name M.I. Last Name

☐ **By checking the box, you are signing this form electronically. You agree your electronic signature is the legal equivalent of your manual signature on this form.**

DS Director Signature: _____ Date: _____