University of Alaska Disability Records Release of Information

University of Alaska recognizes the rights of all individuals to confidentiality of information included in any and all personal records and for professional records maintained by an agency providing treatment services to that individual. University of Alaska also recognizes the rights of students to privacy of student records as required by the Family Educational Rights and Privacy Act (FERPA) of 1974. In most cases, information cannot be released to a third party, except authorized university officials, without your written consent.

Students may use this form to authorize the disclosure and use of their information by the University of Alaska Disability Services Offices as indicated below.

_____ _____

First and Last Name of Student (Print) Date of Birth

_____ _____ _____

UA ID Number Phone Number Email Address

Primary University of Alaska campus you are affiliated with: ☐ UAA ☐ UAF ☐ UAS

UAA Disability Support Services
3211 Providence Dr., Room RH-112
Anchorage, AK 99508
Phone. (907) 786-4530
Fax. (907) 786-4531
e-mail: uaa_dss@alaska.edu

UAF Disability Services
PO Box 755590
Fairbanks, AK 99775
Phone. (907) 474-5655
Fax. (907) 474-5688
e-mail: uaf-disability-services@alaska.edu

UAS Disability Services
11066 Auke Lake Way
Juneau, AK 99801
Phone. (907) 796-6000
Fax. (907) 796-6005
e-mail: uas.disabilityservices@alaska.edu

In accordance with Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990, **I authorize designated representatives of University of Alaska to**:

☐ **release information** from my disability-related educational records to the individual, agency or institution listed below.

☐ **receive information** from the individual, agency or institution listed below related to my diagnosed disability or services previously received in order to determine eligibility for services and accommodations in the postsecondary education setting. Please forward documents to the campus indicated above.

☐ If checked, this document will serve as a **two-way release** between the UA Disability Services Offices indicated above and the individual, agency or institution listed below.

_____ _____ _____

Name of Individual/Department/Office/Institution/Agency Phone Fax

_____ _____

Address City, State Zip

_____ _____

Purpose of Release (Self, School, Agency, Medical Facility, Parent, Legal, etc) Email Address

If records include records or information from a **third party** (health care provider, previous institution, etc.), that information:
☐ should or ☐ should not be released under this Authorization

_____ _____

Signature Date

For Office Use Only: Records released as instructed: By_____ Date_____