

**ST. OLAF COLLEGE**  
**DISABILITY AND ACCESS (DAC)**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

---

**STUDENT NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_

<b>INFORMATION RELEASED FROM:</b>	<b>INFORMATION RELEASED TO/EXCHANGED WITH:</b>
Name:	St. Olaf College Access Specialist
Address:	1520 St. Olaf Avenue
	Northfield, MN 55057
Phone:	Phone: 507-786-3288
Fax:	Fax: 507-786-3923

**AUTHORIZATION TO RELEASE INFORMATION IS LIMITED TO THE FOLLOWING:**

\_\_\_ Psychological/psychoeducational testing

\_\_\_ Progress/meeting notes

\_\_\_ Two-way verbal communication

\_\_\_ Other \_\_\_\_\_

---

**THIS INFORMATION IS TO BE USED FOR:** \_\_\_\_\_

---

I understand that I may revoke this authorization at any time and that, in any event, this consent expires within one year of this date. This information may not be further released without specific consent of the above-named person who is making the disclosure. A photocopy/fax of this authorization will be treated in the same manner as the original.

**SIGNED:** \_\_\_\_\_ **DATE:** \_\_\_\_\_