Release of Information to Disability Support Services

I hereby authorize ____ to:

Release to Disability Support Services at Montana State University Billings the information specified below:

1. Diagnosis of individual's condition.
2. Documentation of individual's condition.
3. Recommendation for academic accommodations.

Name ____
(Last) *(First)* *(Middle)*

Email address ____

Telephone (home) _________________________ *(work/cell)* __________________________

Signature ____ **Date** ______________________

Disability Support Services

Montana State University Billings

University Campus	**City College**
College of Education, Rm 135	Tech Building, Rm A016
1500 University Dr.	3803 Central Ave
(406) 657-2283	(406) 247-3029
(406) 545-2518 V P	(406) 545-1026 V P
(406) 657-1658 fax	(406) 247-3014 fax