



University Campus Office
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Phone: 406-247-3029
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Authorization for Release of Information

I, _____, hereby authorize the release and/or exchange of disability-related records between the office of Disability Support Services at MSU Billings and the following individual(s) and/or agency listed below:

Authorized Individual or Agency

Name of University or Agency: _____

Name of Contact Person: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax: _____

Consent and Understanding

I understand that all information released or exchanged under this authorization is confidential and protected under applicable federal and state laws, including FERPA. This information may not be released to any other party without my written consent.

Student Information

Name: _____

Address: _____

City, State, Zip: _____

Telephone: _____ Fax (if applicable): _____

Signature: _____ Date: _____