



**University Campus Office**  
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3803 Central Avenue  
Billings, MT 59102  
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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: \_\_\_\_\_