

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO

AUTHORIZATION FOR RELEASE OF INFORMATION

I _____ hereby authorize
Print Name

Name of Agency/Program/Person Address

_____ to release to
City, State, Zip

Beth Larivee, M.A., MFT the following information contained in
my records and only under the conditions listed below:
Specific type of information to be disclosed: Documentation of
Disability

The purpose and need for such disclosure: To determine eligibility
and academic support services

This release will expire in 6 months unless otherwise specified:

Signature

Date

Please mark records **CONFIDENTIAL** and **ATTENTION: Beth Larivee** and
send to:

Services to Students with Disabilities
California State University, San Bernardino
5500 University Parkway, UH-183
San Bernardino, California 92407-2397
(909) 880-5238

FAX NO: (909) 880-7090