WESTERN CONNECTICUT STATE UNIVERSITY

AccessAbility Services
Authorization for Release of Disability Documentation

Printed Name:______________________________________ Date: ___________________

Date of Birth:____________________ WCSU ID#:_______________

Request for a copy of disability documentation be released to:

- ☐ Myself
- ☐ WCSU Department:____
- ☐ Transfer Institution:____

Please send the documentation by:

☐ Student Pickup ☐ Mail ☐ Fax ☐ Email

Mailing Address:

____

____

____

Or:

Fax #:____

To the Attention:____

Or:

Email Address:____

Student Signature:____ Date:________

Student Received Signature (if applicable):______________________________ Date:________

AAS Office Use Only –

Prepared by (initials): ______________ Date: _____________

Sent By (mail, email, etc.): ___________ Staff Initials: ________ Date: ______________