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: _____