UNIVERSITY OF
ARKANSAS

Division of Student Affairs
Center for Educational Access

Authorization to Release/Obtain
Confidential Information

NAME ___________________________________ **DATE** _____________________

DATE OF BIRTH____________________________ **STUDENT ID #** ____________________

______ **I hereby authorize the Center for Educational Access to release confidential educational information and/or other records to:**

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______ **I hereby authorize the University of Arkansas Center for Educational Access to obtain confidential information and/or other records including medical and/or psychological testing, evaluation and treatment concerning the above named individual from:**

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This authorization expires 60 days from the date it is signed. I understand that I may revoke this authorization, in writing, at any time prior to the release of the information specified above.

________________________________ ____________________________________
Signature **Date** **Witness** **Date**

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