AUGUSTA UNIVERSITY

Testing and Disability Services

AUTHORIZATION FOR RELEASE OF RECORDS

In signing this statement, I, _____ authorize

_____ to release information concerning me to

_____

_____

The information that I am authorizing to be released includes the following:

_____ total records _____ summary report of counseling

_____ Test results _____ other (specify)_____

_____ summary of test results _____

The purpose for which this information will be released: _____

_____

_____

_____ _____
Signature Date

_____ _____
Witness Date

** This authorization is good until _____.
(date not to exceed 30 days from date signed)