Release of Information

I, _____ CWU ID#: _____ Date of Birth: _____
(Please print: Student First/Last Name)

AUTHORIZE: ***CWU Office of Case Management***
400 East University Way, Ellensburg, WA 98926
Phone: (509) 963-1515 / Fax: (509) 963-7857

TO EXCHANGE INFORMATION WITH THE FOLLOWING PERSON/AGENCY/SERVICE PROVIDER:

Name: _____

Address: _____

Phone/Fax #: _____

Email Address: _____

THIS RELEASE AUTHORIZES THE EXCHANGE OF INFORMATION FOR PURPOSES OF:

☐ Coordination/Continuity of Care ☐ Other: _____

By completing and signing this Release of Information, I understand that no disclosure of my records can be made by the CWU Office of Case Management to non-CWU entities without my written consent, unless otherwise provided by law. I understand that I may revoke this authorization in writing at any time, except to the extent that information has already been released.

This authorization will expire (***initial one only***):

_____ Sixty (60) days from the date below authorizing this release;

_____ Six (6) months from the date below; or

_____ On the date this record is destroyed, or on the date that I am no longer a student at Central Washington University, whichever date further extends this release.

X_____ _____ _____
Student Signature ***Date*** ***(CWU Official Initials)***