



# Montana State University Great Falls

2100 16<sup>th</sup> Avenue South, Great Falls, MT 59405

Phone: (406)-771-4311 Fax: (406)-771-4342

College of Technology

## Authorization for Release and Exchange of Information

Please print and fill out this form mail it to Disability Services at the address above or fill out the form and return it as an email attachment to: [katherine.meier@msugf.edu](mailto:katherine.meier@msugf.edu).

I, \_\_\_\_\_, do hereby authorize the release and exchange of the following information:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

between the following individuals and/or agencies:

Name: \_\_\_\_\_  
Title: \_\_\_\_\_  
Business/Agency: \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Fax: \_\_\_\_\_

and

*Disability Services  
Montana State University—Great Falls College of Technology  
2100 16<sup>th</sup> Avenue S  
Great Falls, MT 59405  
(406) 771-4311(Voice/TTY)  
Fax: (406) 771-4342*

I understand that all information released and/or exchanged is confidential and may not be released to any party other than those listed above without my written consent. I also understand that I may cancel this agreement at any time by notifying either party listed above in person or in writing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
Name (printed): \_\_\_\_\_  
Address: \_\_\_\_\_  
City/State/Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

This authorization will expire two years from the date signed, unless otherwise noted here: \_\_\_\_\_