

GEORGE MASON UNIVERSITY  
**DISABILITY RESOURCE CENTER**  
*DISCLOSURE AUTHORIZATION FORM*

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**Name of Student** **G#**

**I authorize the Disability Resource Center at George Mason University to:**

\_\_\_\_\_ **Exchange with**

\_\_\_\_\_ **Disclose to**

\_\_\_\_\_ **Obtain from**

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**Name and/or Organization**

**Address**

**The following information:**

\_\_\_\_\_ **Psychological Evaluations**

\_\_\_\_\_ **Neuropsychological Evaluations**

\_\_\_\_\_ **Psychological/Psychiatric Evaluations**

\_\_\_\_\_ **Medical Records**

\_\_\_\_\_ **Other**

**For the following purpose(s):**

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*I understand that my records are protected under Federal and State confidentiality laws and regulations.*

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**Signature of Student**

**Date**

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**Witness**

**Date**