**Information Exchange Authorization**

 I hereby request and authorize the following two parties to exchange information from my records:

**Accessibility Services**

**California State University, East Bay Name of Person | Agency | Organization**

 **25800 Carlos Bee Boulevard, LI 2400** **Address**

 **Hayward, CA 94542**

 **Address**

 **4700 Ygnacio Valley Road, AS 114**

 **Concord, CA 94521 Phone | Email Address**

This exchange of information shall be limited to the following items:

  Diagnosis  Assessments  Accommodations  Psycho-Educational Evaluation

  Other:

I understand that this authorization becomes effective immediately and is subject to revocation by me at any time. If not earlier revoked, it shall terminate upon my graduation or exit from Cal State East Bay.

A photocopy of this form is as valid as the original.

 **STUDENT’S signature STUDENT’S NAME (PLEASE PRINT)**

 **DATE date of birth net id**