



## 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**

25800 Carlos Bee Boulevard, LI 2400  
Hayward, CA 94542

4700 Ignacio Valley Boulevard, AS 114  
Concord, CA 94521

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NAME(S)/ORGANIZATION

EMAIL ADDRESS(ES)

PHONE NUMBER(S)

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

DATE

DATE OF BIRTH

NET ID