University of Massachusetts Lowell
Learning with Purpose

Wellness Center, University Crossing
220 Pawtucket Street, Suite 300
Lowell, Massachusetts 01854
Tel. 978.934.6800
Fax: 978.934.2032
Email: Disability@uml.edu

DISABILITY SERVICES

PERMISSION TO RELEASE and EXCHANGE INFORMATION

Name of Student: _____

Student ID: _____

I give my permission to the UMASS Lowell Disability Services Coordinator, to discuss pertinent educational, psychological, and/or medical records for the purpose of providing disability support services at UMASS Lowell. This includes contact by e-mail, fax, and telephone. A copy of this permission shall have the same force as the original.

I give permission for information to be released TO or FROM the following:

Name	Agency/Relationship	Contact Information

☐ UMASS EMTs ☐ External Agencies

Note: I understand and agree that the information will be released effective until the UMASS Lowell Services has received written notice to revoke this form.

_____ _____

Student Signature **Date**