RELEASE OF INFORMATION FROM:

_____________________________________________
_____________________________________________
_____________________________________________

I hereby request and authorized you to release the information indicated below to the Disability Resource Center at Northern Illinois University:

___ Academic Performance Records/Achievement Testing
___ Individual Educational Plan/Program (IEP)
___ Psychoeducational Diagnostic Evaluation
___ Medical Reports/Records
___ Speech and Hearing Evaluation/Audiogram
___ Attention Deficit Disorder Evaluation/Treatment/Recommendations
___ Other

Name (print) __________________________________________ Z # _______________________

Signature __________________________________________ Date: _______________________

Parent/Guardian Signature (if under 18 years of age) _______________________________________

SEND TO: DISABILITY RESOURCE CENTER
          HEALTH SERVICES 400
          NORTHERN ILLINOIS UNIVERSITY
          DeKalb IL 60115