



Affirmative Action Release Authorization

- Physician Counselor Psychologist
 RFB&D (Record for the Blind and Dyslexic) Other
-

To: _____
Professional's name (please print)

Address: _____

City: _____ State: _____ Zip: _____

I HEREBY REQUEST AND AUTHORIZE THE RELEASE OF MEDICAL/EMPLOYEE RECORDS OR OTHER PERTINENT INFORMATION WHICH WILL ASSIST IN MY EMPLOYMENT PURSUITS TO:

Office of Affirmative Action
c/o Sheila Bryant, Director
Austin Peay State University
P.O. Box 4457
Clarksville, TN 37044

I FURTHER AUTHORIZE THAT A PHOTOCOPY OF THIS AUTHORIZATION BE FULLY ACCEPTABLE AS AN ORIGINAL. THIS AUTHORIZATION WILL BE VALID AS LONG AS I AM AN EMPLOYEE OF AUSTIN PEAY STATE UNIVERSITY.

Employee's Name (Print)

Employee ID ("A" Number)

Employee's Signature

Date