

DISABILITY RESOURCES & SERVICES

AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Student: _____ Student ID# or MEID: _____

Address: _____

Cell Phone: _____ Other Phone: _____

The following release statement is strictly voluntary and may be modified:

I understand my disability information is protected under applicable Federal and/or State law and cannot be disclosed without my consent. I retain the right to revoke this consent at any time, except to the extent that action has already been taken in reliance to it.

I hereby give consent and authorize the South Mountain Community College (SMCC) Disability Resources & Services (DRS) office to receive and/or release relative information to the parties indicated below regarding my disability, academic progress, and/or academic adjustments necessary to accommodate my disability or otherwise benefit my academic progress.

- South Mountain Community College Faculty and Staff
- I hereby give consent and authorize the South Mountain Community College (SMCC) Disability Resources & Services (DRS) office to collaborate with my instructors as well as provide them an electronic CINF form.
- Community Service/Other Agencies (related to educational goals)
- Medical/Health Providers (disability documentation)
- Other: _____

This authorization will remain in effect until such time as I (or my agent or guardian) may revoke it with writing. Without my express revocation, this consent will expire upon graduation.

Student Signature: _____

Parent (or Guardian) Signature: _____