

Consent for the Exchange/Release of Information

Instructions: The student must complete this form in its entirety in order for Disability Support Services to release any information. The student and/or requesting party must be specific as to the nature of the information he/she would like released and the purpose for which it is required.

I authorize the professional staff of Disability Support Services to:

- Exchange information/records, as specified, with
 Release information/records, as specified, to:

<p>Diablo Valley College Disability Support Services Student Service Center 202B 321 Golf Club Rd Pleasant Hill, CA 94523</p>	OR	<p>_____ Name of Person/College to receive records/information (Please Print)</p> <p>_____ _____</p> <p>_____ _____</p> <p>_____ _____</p> <p>Street Address City/State Zip</p>
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Records to be disclosed:

- | | | |
|--|---|--|
| <input type="checkbox"/> Medical | <input type="checkbox"/> Psychiatric Evaluation | <input type="checkbox"/> Neurological Assessment |
| <input type="checkbox"/> LD Assessment | <input type="checkbox"/> Accommodations | <input type="checkbox"/> Other _____ |

I hereby release the college from all legal liability that may arise from the information requested. I hereby certify that this request has been made freely, voluntarily and without coercion. Information given is accurate to the best of my knowledge and I understand that I may revoke this authorization at any time.

<p>_____ Print Name of Authorizer</p> <p>_____ Student I.D. Number</p> <p>_____ Street Address</p> <p>_____ Witness of Signature</p>	<p>_____ Signature of Authorizer</p> <p>_____ Phone Number</p> <p>_____ City, State, Zip</p> <p>_____ Signature of Parent or Guardian (if student is under 18 years of age)</p>
<p>_____ Date</p>	