CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Disability Support Services (DSS)

TO:

Name of Agency/School

Address

City/State/Zip Code

FROM:

Student Name

Address

City/State/Zip Code

Date of Birth

You are hereby authorized to release pertinent medical, psychological, social or educational information that the following agency and/or person may request about me. Send information to:

Disability Support Services
Big Bend Community College
7662 Chanute Street NE.
Moses Lake, WA 98837
Phone: 509.793.2027
TDD: 509.793.2325
FAX: 509.762.3648

Information Requested:_____

This information will be used only as an aid in providing educational support services for which I have applied.

The requesting agency/person has the responsibility of keeping this information confidential and will not release this information to any other agency or person without my written consent.

Student Signature

Date

Revised 6/4/18