CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION
Disability Support Services (DSS)

I, (Student Name) ________________________________ do hereby give permission to the Coordinator of Disability Services at Big Bend Community College to provide and/or receive pertinent medical, psychological, social, disability or educational information to/from the following persons or agencies:

Please list by name:

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This information may be used to assist in determining and implementing appropriate accommodations, modifications, and/or services.

________________________________ ________________________________
Student Signature Date

Revised 6/5/18