SANTA ANA COLLEGE
DISABLED STUDENTS PROGRAM & SERVICES
Phone: (714) 564-6295 Fax: (714) 285-9619

RECORDS REQUEST:

I will pick up a copy of my records or receive it by email (present a picture ID)

Email: _____

Name: _____ Date of Birth: _____

Other name(s) used: _____ Student ID#: _____

SIGNATURE: _____ **DATE**: _____

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the Santa Ana College Disabled Students Program & Services to transmit information regarding my educational development, campus activities, and other data pertaining to my disability (ies) requested by the agencies, companies or persons indicated below. Data transmission may be in oral, written, fax or electronic format.

Doctor or Therapist Name: _____

Family Member: Name: _____

Potential Transfer Universities and Colleges: _____

Department of Rehabilitation: _____

Professional/Crisis Contact: _____

Other: _____

SIGNATURE: _____ **DATE**: _____

NAME: _____ **STUDENT ID#:** _____

_____ **DATE**: _____

SIGNATURE OF PARENT OR GUARDIAN *(required for student under 18 years of age)*

This authorization shall remain in effect until revoked in writing.

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL