

CONSENT FOR EXCHANGE OF INFORMATION

SANTA ANA COLLEGE

DISABLED STUDENT PROGRAMS & SERVICES

1530 W. 17th Street, Santa Ana, CA 92706

Phone: (714) 564-6264 Fax: (714) 285-9619

http://www.sac.edu/students/support_services/dsps/

TO: _____ **FAX:** _____
Agency or Certifying Professional

_____ Address City State Zip

FROM: _____ **PHONE:** _____
DSPS Contact

_____ **FAX:** _____
DSPS Program/Location

_____ Name of Student Date of Birth

_____ Maiden Name or Other Name Used Student ID#

I request and authorize all appropriate persons and/or agencies or institutions to release information regarding my disability(ies) to Santa Ana College. I understand that this information will be used to determine my eligibility for special services and/or accommodations. This information will be used consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations or policies in compliance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. All information will be kept confidential and maintained as part of my records with the Disabled Student Programs & Services office.

I authorize the release of information to include one or more of the following records:

INITIAL:

- _____ Verification of Disability/Diagnosis
- _____ Psychological Test/Evaluation Results (RAW SCORES PLEASE)
- _____ Learning Disability Assessment
- _____ Audiological and/or Speech/Language Pathology Reports
- _____ Individual Plan for Employment
- _____ Prescribed Medications and Dosage
- _____ Educational Assessments, Reports and Records including High School Transcripts
- _____ Certification of Conditions/Limitations
- _____ Other: _____

SIGNATURE OF STUDENT **DATE**

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

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL

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DISABLED STUDENT PROGRAMS & SERVICES
Phone: (714) 564-6264 Fax: (714) 285-9619

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the Santa Ana College Disabled Student Programs & 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.

INITIAL:

_____ Department of Rehabilitation: _____

_____ High School District: _____

_____ Doctor or Therapist: Name: _____

Name: _____

_____ Family Members: Name: _____

Name: _____

Name: _____

_____ Potential Transfer Universities and Colleges

_____ Recording for the Blind and Dyslexic (RFB&D)

_____ Other _____

_____ Other _____

_____ Professional/Crisis Contact: _____

Phone: () _____

SIGNATURE: _____ **DATE:** _____

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

_____ **DATE:** _____

SIGNATURE OF PARENT OR GUARDIAN

(required for student under 18 years of age)

PLEASE NOTE: This consent will remain valid until such time as it is rescinded in writing.

I hereby rescind the above consent for release of information to _____

SIGNATURE: _____ **DATE:** _____

NAME: _____

DSPS SPECIALIST: _____ **DATE:** _____

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL

RELEASE FORM 6/30/08 rm