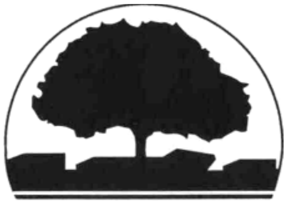
FAX _______________
Date _______________



CENTRALIA COLLEGE

Center for Disability Services

Improving people's lives through life-long learning.

CONSENT FOR RELEASE OF INFORMATION

I, ________________________ , authorize ______________________________________
(please print your name) (name of professional if known)

of _____________________________, to disclose to the Center for Disability Services of
(name of agency/organization)
Centralia College, the following records or information:

Appropriate documentation needs to include diagnosis, prognosis, and functional limitations.

Information Requested

- ☐ Intake Evaluation
- ☐ Medical Records
- ☐ Psychiatric Evaluation
- ☐ Psychological Test Results
- ☐ Treatment Plan
- ☐ Lab Reports
- ☐ IEP/Special Ed Records

Purpose of Information

- ☐ Educational Planning
- ☐ Coordinate Accommodations
- ☐ Evaluate documentation for coverage under Section 504 and ADA
- ☐ Assess functional limitations
- ☐ ______________________Other (specify)

The above requested information will be used for educational planning and accommodation. I understand that my records are protected under confidential regulations and laws and cannot be disclosed without this written consent unless the law authorizes or compels us to do so. I also understand that I can revoke this consent at any time.

____
(Signature) (Date)

____
Social Security Number (optional)

Send report on letterhead to:
Michael Hoel, Interim Director
Center for Disability Services Office
600 W. Centralia College Blvd.
Centralia, WA 98531
Fax: 360-330-7501