Disability Services
1973 Edison Drive | Piqua, OH 45356
Phone (937) 778-7837 | Fax (937) 778-4692

RELEASE OF INFORMATION

Name: _____ Student ID: _____

I authorize Disability Services to release information about my learning and education to the individuals indicated below. These individuals also have my permission to share verbal and written information with Disability Services deemed necessary and appropriate as related to my learning and education.

☐ All professors

☐ Others: Name Relationship

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

All information will be considered confidential and only released to appropriate personnel on a need to know basis. This consent will automatically expire when I graduate/withdraw or otherwise leave Edison State Community College. I understand that this authorization is voluntary and that I may refuse to sign this authorization. I understand I may withdraw this authorization at any time by written notification to the parties involved.

Student Signature:_____ Date:_____