

**HOBART AND WILLIAM SMITH COLLEGES  
DISABILITY SERVICES, CENTER FOR TEACHING AND LEARNING**

**DISABILITY RELEASE OF INFORMATION**

**NAME** \_\_\_\_\_ **DOB** \_\_\_\_\_ **ID#** \_\_\_\_\_

I hereby give permission to **Disability Services (CTL)** to give/receive information related to my disability for the purpose of providing academic support to/from:

_____ <b>Parents</b>	_____ <b>Hubbs Health Center</b>
_____ <b>HWS Dean's Office</b>	_____ <b>Counseling Center</b>
_____ <b>My advisor</b>	_____ <b>Athletic Department</b>
_____ <b>Instructors</b>	_____ <b>Office of Residential Education/Dining Services</b>
_____ <b>Physician/Psychologist</b>	_____ <b>Other (Specify)</b> _____

***Information Requested:***

_____ <b>Academic Performance</b>	_____ <b>Medical Records</b>
_____ <b>Accommodations</b>	_____ <b>Psychological Evaluation</b>
_____ <b>Attendance/Punctuality</b>	_____ <b>Educational Evaluation</b>
_____ <b>Other (Specify)</b> _____	

I have been told that in order to protect the limited confidentiality of records, my agreement to obtain or release information is necessary, and that this permission is limited to the purposes and to the persons/departments listed above. This release will be effective for 365 days from the date of my signature. I understand that I will be told to whom, and dates when information will be sent. I understand that by written statement, I may withdraw my permission at anytime. I also understand that I may ask to see the information that is to be sent.

FEDERAL REGULATIONS PROHIBIT DISCLOSURE OF THIS INFORMATION WITHOUT YOUR SPECIFIC WRITTEN CONSENT.

\_\_\_\_\_  
**SIGNATURE**

\_\_\_\_\_  
**DATE**

This information has been disclosed from records whose confidentiality is protected by Federal and State Law. Federal and State regulations limit the right to make any further disclosure of this information without the prior written consent of the person to whom it pertains.