

**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:

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

Information Requested:

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

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.