SEATTLE CENTRAL COLLEGE
Accessibility Resource Center

Seattle Central College - Accessibility Resource Center

AUTHORIZATION FOR RELEASE OF INFORMATION

Date of Request: _____

Student Authorizing Release: _____

Student's Email: _____

Student's DOB: _____

Student's ctcLink ID: _____

I Hereby authorize the following (institution, agency, physician, psychologist, or another provider):

Provider's Name: _____

Provider's Street Address: _____

City, State, Zip Code: _____

Provider's Email: _____

Provider's Phone: _____ **Fax:** _____

To provide the following information:

- ☐ Medical records with diagnosis of disability & duration of condition & limitation(s)
- ☐ Psychological testing and evaluation results
- ☐ Learning disability assessment
- ☐ Vocational Rehabilitation Plan/ Accommodation Plan
- ☐ Other (Be specific): _____

Release to:

Seattle Central College
Accessibility Resource Center (ARC)
1701 Broadway, Room BE 1103
Fax: 206.934.3236
Phone: 206-934-4183

READ THE STATEMENT BELOW BEFORE SIGNING

I hereby release the authorized person and/or institution above of all legal responsibility or liability for the one-time disclosure of the information, indicated above, to Seattle Central College ARC office to assist with planning and implementation of my academic and/or vocational goals. This information will not be disclosed to any third-party agency or individual without my consent. The confidentiality of this information is protected by state laws (RCW 70.02.030) and federal law (PL 93-380, the Federal Family Education Rights and Privacy Act of 1974), and it complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

Printed Name of Student: _____

Student Signature: _____ **Date Signed:** _____

If the above student is under the age of 18 a parent/legal guardian signature is required

Print Name of Parent/Legal Guardian: _____

☐ **Parent** ☐ **Legal Guardian** ☐ **Other:** _____

Signature of Parent/Legal Guardian: _____ **Date Signed:** _____