

**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: