

# Central Carolina Community College

11/06

1105 Kelly Drive • Sanford, NC 27330

Special Populations Services

919-718-7273

1-800-682-8353, ext.7273

## Consent for Release of Confidential Information

I, \_\_\_\_\_, authorize Central Carolina Community College Special Populations Services to discuss (1) the nature of my disability, (2) the particulars of my academic progress, and/or (3) other selected, appropriate information that is deemed necessary to plan and implement appropriate accommodations that will provide equal access to Central Carolina facilities and programs.

### Please initial your choice(s)

	YES	NO
Parents	_____	_____
Central Carolina Faculty and Staff	_____	_____
Agency Counselors	_____	_____
Therapist	_____	_____
Other: _____	_____	_____
_____	_____	_____

**Agencies or programs** of which you are a client or from which you receive financial aid and/or other support (e.g., Division of Services for the Blind, Vocational Rehabilitation, Department of Veterans Affairs)

\_\_\_\_\_ Agency \_\_\_\_\_ Address

\_\_\_\_\_ Counselor \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

\_\_\_\_\_ Agency \_\_\_\_\_ Address

\_\_\_\_\_ Counselor \_\_\_\_\_ Phone \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip

Agency		Address		
Counselor	Phone	City	State	Zip

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I may revoke this consent at any time except to the extent that action has been taken. This authority expires with the completion of all transactions related to services provided by Central Carolina Community College Special Populations Support Services.

Student's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness's signature: \_\_\_\_\_ Date: \_\_\_\_\_