

# Central Carolina Community College

1105 Kelly Drive • Sanford, NC 27330

Special Populations Services

919-718-7273

1-800-682-8353, ext.7273

## Consent for Release of Confidential Information

*To be completed and signed by student*

I, \_\_\_\_\_, authorize  
(Name of student)

\_\_\_\_\_  
*(Name of program, person, doctor, counselor or institution making the disclosure not CCCC)*

at \_\_\_\_\_  
(Address and telephone of program)

to disclose to Central Carolina Community College Special Populations Services, the following information:

Disability Verification: To be completed by a qualified professional and returned to Central Carolina Community College along with Documentation.

This information will be used to verify the need for specialized services to plan and implement appropriate accommodations that will provide equal access to Central Carolina programs and facilities. The use or release of this information is limited to purposes directly with the administration of Special Populations Services. I understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent will expire automatically within one (1) year from this date unless otherwise specified.

**Disability verification can be acquired from qualified professionals such as attending physicians, counselors from the Division of Services for the Blind, the Office of Vocational Rehabilitation, the Department of Veterans Affairs, psychologists, etc. If your disability has not previously been documented, please call Special Populations Services for resource guidance.**

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip

\_\_\_\_\_  
Telephone

Disability Statement  
To be completed and signed by certifying authority

This is to certify that \_\_\_\_\_ is requesting assistance at Central Carolina Community College in one of the following areas:

- |                                                        |                                                        |
|--------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Behavioral/Emotional Handicap | <input type="checkbox"/> Specific Learning Disability  |
| <input type="checkbox"/> Educable Mental Handicap      | <input type="checkbox"/> Speech/Language Impairment    |
| <input type="checkbox"/> Deaf/Hard of Hearing          | <input type="checkbox"/> Visual Impairment             |
| <input type="checkbox"/> Orthopedic Impairment         | <input type="checkbox"/> Autism                        |
| <input type="checkbox"/> Traumatic Brain Injury        | <input type="checkbox"/> Other Health Impairment _____ |
| <input type="checkbox"/> Attention Deficit Disorder    | _____                                                  |

The law defines a person with a disability as anyone with a physical or mental impairment that substantially impairs or restricts one or more major life activities, such as:

- |                         |                 |                           |
|-------------------------|-----------------|---------------------------|
| • caring for one's self | • sitting       | • interacting with others |
| • speaking              | • concentrating | • performing manual tasks |
| • hearing               | • reading       | • seeing                  |
| • walking               | • sleeping      | • learning                |

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**Please enclose copies of the following information:**

- |                                                                                                       |                                                |
|-------------------------------------------------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Psychological Report/Psychiatric Report                                      | <input type="checkbox"/> Audiogram             |
| <input type="checkbox"/> Educational Report                                                           | <input type="checkbox"/> Vocational Evaluation |
| <input type="checkbox"/> Medical History                                                              | <input type="checkbox"/> Verbal Communication  |
| <input type="checkbox"/> IEP                                                                          | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> Any Information Necessary to document disability and need for accommodations |                                                |

**Certifier Information:**

Name of Certifier: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Print or type)

Professional Capacity: \_\_\_\_\_

Place of Employment: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Signature of Certifier: \_\_\_\_\_ Date: \_\_\_\_\_

**Return completed form to: David Oates, Special Populations Director  
1105 Kelly Drive, Sanford, NC 27330**