Student disAbility Resource Center
1000 E. Victoria St., Carson, CA 90747 • Tel 310-243-3660 • Fax 310-516-4247 • dss@csudh.edu

Consent for Release of Information

I hereby authorize the **Student disAbility Resource Center** to release to the person/ office, medical, psychological, and/or educational information pertaining to my needs named below:

Date: _____

From: _____

To: _____

_____

_____

I authorize the release and/or exchange of confidential information to include one or more of the following records:

- ☐ Verification of Disability
- ☐ Learning Disability Assessment (include Scores)
- ☐ Educational Records, including Progress
- ☐ Audiological & Speech/Language Pathology Reports
- ☐ Vocational Rehabilitation Plan
- ☐ Prescribed Medications & Dosages
- ☐ Psychological testing and evaluation
- ☐ Other (relative to Educational Limitations)

_____

_____

_____

Print Student Name Student Signature

_____

Student I.D #

Student disAbility Resource Center Only:

Action Taken: _____ Authorizing Staff Signature: _____

Approved/ Denied: _____ Date Action Taken: _____

Appointment is needed._____

No Record(s) Found_____