

CONSENT TO RELEASE CFCC STUDENT ACCESSIBILITY SERVICES INFORMATION

I, _____, (DOB: ____ / ____ / ____) authorize Cape Fear Community College Student Accessibility Services to disclose to/receive information from:

- CFCC Faculty & Staff
- Parent/Family _____
- Other _____

the following specific information: Mutual exchange of information for educational planning & CFCC SAS service provision. Information to include name, address, phone number, social security number, diagnoses, medical/mental health data, diagnostic evaluations, educational records, disability related information.

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent. I understand I may revoke this consent at any time except to the extent that action has been taken.

Signature of Student

Signature of Parent, Guardian, or Authorized Representative, (when required)

Date

Confidential

The information is provided by the Student Accessibility Services office for the purpose of educational planning. We appreciate the respect for the student's confidentiality and your understanding that state and federal laws prohibit the release of this information to any other person or agency or for use in any manner for any other purpose. Students with disabilities are eligible for appropriate services stipulated under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. Student Accessibility Services has received all necessary documentation that substantiates the student's need for academic accommodations.

REVOCATION SECTION

I do hereby request that this authorization to disclose health information of

_____ signed by _____
(Student Name) (Name of Person Who Signed Authorization)

on _____ be rescinded, effective _____. I understand that any
(Enter Date of Signature) (Date)

action taken on this authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Student) (Date) (Signature of Witness) (Date)

_____ _____
(Signature of Personal Representative) (Date) (Personal Representative
Relationship/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by

_____ on _____.
(Name of Student or Personal Representative) (Date)

The student or their personal representative has been informed that any action taken on this
authorization prior to the rescinded date is legal and binding.

_____ _____ _____ _____
(Signature of Staff) (Date) (Signature of Witness) (Date)

Confidential

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