

Please print legibly. If information is not readable, it cannot be processed.



Trinity Valley Community College
Students with Disabilities

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Student ID # _____ Name: _____

Cell Phone: _____ Email: _____

I, _____, authorize the TVCC Student Disability Office to release the following information/materials for the purpose of assisting me in my academic program (provide a specific and detailed description of the information you want disclosed):

Persons to whom information may be released (please print clearly):

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

AND TVCC Faculty, as per my student schedule to help in my educational needs.

This authorization shall remain in effect until _____.

I am requesting the Trinity Valley Community College disability services office to release this information for the following reasons ("At the request of the individual" is all that is required if you do not desire to state a specific purpose): _____

I understand that I may revoke this release, in writing, at any time by sending such written notification to the disability services office. By signing this release, I understand TVCC will not contact these individuals, but may release information to those noted if applicable.

Student Signature: _____ Date: _____