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UMPQUA COMMUNITY COLLEGE

DISABILITY SERVICES
P.O. Box 967 Roseburg, OR 97470-0226

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I authorize release of my records to the Disability Services Office at Umpqua Community College to help me with my program and classroom goals.

NAME _____ Date of Birth _____

SS# _____ PHONE _____

ADDRESS _____

I authorize the following individuals or agencies:

NAME: _____

ADDRESS: _____

to provide information to:

Umpqua Community College PO Box 967
Barbara Stoner, Coordinator Roseburg, OR 97470-0226
Disability Services

Including records of:

- | | | | |
|------------------------------|-----------------------------|--------------------------------|---|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Family History | <input type="checkbox"/> Special Eligibility (LD) Documentation |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Educational Reports | <input type="checkbox"/> Evaluation Reports |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Alcohol/Drug Treatment | <input type="checkbox"/> Accommodations used in High School |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Mental Health Services | <input type="checkbox"/> Other as listed: |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Medical/ Psychiatric Treatment | |
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | Cognitive Assessment | |

Alcohol/Drug, Mental Health and Medical Records include all aspects of diagnosis, treatment and prognosis.
Educational records include both behavioral and progress reports.

*I acknowledge that information to be released may include material concerning disability issues that Federal Law protects. My signature below authorizes release of all such information to a representative of Umpqua Community College. I understand that this information becomes void after one year from the date below or on: _____. I understand that I may revoke this consent at any time with a written statement to the UCC Disability Services Dept. except to the extent that action has already been taken.
It is my understanding that all information received by Umpqua Community College because of this authorization will be treated as confidential.*

Signature

Date