SOUTHERN UNION
STATE COMMUNITY COLLEGE

Believe it. Achieve it.

ADA Authorization for Release of Information

Name: _____ Student Number: _____

Address: _____

Contact Number: _____

Email: _____ Birth Date: _____

Release of Information:

This authorization applies to the following information:

_____ Supporting medical documentation
_____ Accommodations currently provided

The information may be released to:

_____
Individual/Agency/Organization receiving Information

_____
Street Address City, State, Zip Code

_____
Phone Email

Purpose:

The student's information will be released for the following purpose(s):

_____

This authorization is valid from the date of signature and will remain in effective until the student is no longer enrolled at Southern Union State Community College or the student revokes consent.

I understand that I may revoke this authorization at any time in writing sent to the ADA Coordinator.

_____
Student Printed Name Student Signature Date: