

ACCESS Disability Services

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME: _____

MDC Student ID #: _____

Check One:

_____ I authorize the release of pertinent information concerning my disability to the faculty/staff members of Miami Dade College. The ACCESS Disability Services office determines who should receive it. I understand this information will be used to arrange for appropriate accommodations to meet the course requirements, or to participate in other college activities.

_____ I do not authorize the release of information concerning my disability. I understand that I qualify for general academic services, but that this authorization eliminates the provision of modifications to course requirements or other college activity.

_____ I authorize the release of pertinent information concerning my disability to:

I understand and have discussed with the ACCESS Disability Services staff that all information concerning disability issues will be kept confidential, except for appropriate members of the college staff on a need to know basis.

Signature

Date