

**MIAMI DADE COLLEGE**  
**Mitchell Wolfson New World Center Campus**  
**ACCESS SERVICES DEPARTMENT, Room 1180**  
**300 N.E. 2<sup>nd</sup> Avenue, Miami, FL 33132-2297**

**AUTHORIZATION FOR RELEASE OF INFORMATION**

Date: \_\_\_\_\_

\_\_\_\_\_  
Name of Agency, School, Medical Doctor, or Psychologist

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Zip Code

\_\_\_\_\_  
Telephone Number Fax Number

**TO WHOM IT MAY CONCERN:**

\_\_\_\_\_ (Social Security No. \_\_\_\_\_)  
has applied to us for assistance through our disabled student services department (ACCESS Services).  
We would appreciate the results of any of the following:

- Psychological Tests       Medical Data       L.E.P.'s  
 Psycho-Educational Evaluations       Counselor's Recommendations  
 Other applicable information regarding this person

**\* We would also appreciate any suggestions on how to best serve this student on a collegiate level.**

The student understands that his or her signature on this document is an approval of a release of their records to the ACCESS Department.

Thank you for your attention to this communication. You may **FAX** documents directly to ACCESS at (305) 237-3464. If you have any questions, please contact the ACCESS Department at (305) 237-3072.

\_\_\_\_\_  
Resource Advisor, ACCESS Services

Please release my records to the ACCESS Services Department at the above address.

Student's current address: \_\_\_\_\_

Student's current telephone: \_\_\_\_\_

Date(s) associated with your agency/school: \_\_\_\_\_

Student Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_