CONSENT FOR EXCHANGE OF INFORMATION

SANTA ANA COLLEGE
DISABLED STUDENTS PROGRAMS & SERVICES
1530 W. 17th Street, Santa Ana, CA 92706
Phone: (714) 564-6264 Fax: (714) 285-9619
http://www.sac.edu/students/support_services/dsps/

Name: _____Date of Birth: _____

Other name(s) used: _____Student ID#: _____

TO: _____Fax #:_____
(High School, Agency or Certifying Professional)

_____
Address *City* *State* *Zip*

FROM: Santa Ana College, DSP&S Office; _____
(DSP&S Contact)

Phone #: _____ Fax #: _____

I request and authorize all appropriate persons and/or agencies or institutions to release information regarding my disability (ies) to Santa Ana College. I understand that this information will be used to determine my eligibility for special services and/or accommodations. This information will be used consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations or policies in compliance with Section 504 of the Rehabilitation Act and the Americans with Disabilities Act. All information will be kept confidential and maintained as part of my records with the Disabled Student Programs & Services office.

I authorize the release of information to include one or more of the following records:

INITIAL:
____ Verification of Disability/Diagnosis with description of functional limitations
____ Learning Disability Assessment
____ Audiological and/or Speech/Language Pathology Reports
____ Individual Plan for Employment
____ Prescribed Medications and Dosage
____ Multidisciplinary Assessment Report, Psych Ed Report, IEP (most recent)
____ High School Transcripts
____ Completion of attached Disability Verification Form
____ Other:

_____ _____
SIGNATURE OF STUDENT **DATE**

_____ _____
SIGNATURE OF PARENT OR GUARDIAN **DATE**
(*required for student under 18 years of age)*

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL

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RECORDS REQUEST: Please check the appropriate request below.

Name: _____ Date of Birth: _____

Other name (s) used: _____ Student ID#: _____

☐ I will pick up a copy of my records (present a picture ID)
☐ Please fax my records to the Agency/College/University listed below

RELEASE OF INFORMATION
I hereby request and authorize Santa Ana College Disabled Student Programs & Services to release any medical, social, educational, and/or psychological information they have pertaining to me to the party named below.

Name: _____ Title/Relationship: _____

Address: _____
Street *City* *State* *Zip*

Phone #:_____ Fax #:_____

SIGNATURE: _____**DATE**:_____

CONSENT FOR RELEASE OF INFORMATION

I hereby authorize the Santa Ana College Disabled Student Programs & Services to transmit information regarding my educational development, campus activities, and other data pertaining to my disability (ies) requested by the agencies, companies or persons indicated below. Data transmission may be in oral, written, fax or electronic format.

INITIAL:

_____ Doctor or Therapist Name: _____

_____ Family Member: Name: _____

_____ Potential Transfer Universities and Colleges: _____

_____ Department of Rehabilitation: _____

_____ Professional/Crisis Contact: _____

_____ Other: _____

SIGNATURE: _____ **DATE**: _____

NAME: _____ **STUDENT ID#:** _____

_____ **DATE**: _____
SIGNATURE OF PARENT OR GUARDIAN *(required for student under 18 years of age)*

This authorization shall remain in effect until revoked in writing.

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