



STUDENT DISABILITY SERVICES

Parent/Agency Release

I, _____ hereby request and authorize the following parties to exchange pertinent information pertaining to my participation in Student Disability Services and my academic progress.

1. Student Disability Services Western New England College Springfield, MA 01119 (413) 782-1257

2. Parent: _____ Phone: _____ Address: _____ Clinician/Psychologist: _____ Phone: _____ Address: _____
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This information includes: intake reports and diagnosis, progress notes, treatment/discharge summary, history, physical exam, hospitalization/inpatient records and psychological testing. This information is to be exchanged in order to provide optimal academic support.

I authorize the release and receipt of information related to my involvement with Student Disability Services. I understand that I may revoke this authorization at any time in writing, but that this request will remain valid until **otherwise noted**.

A photocopy of this form is as valid as an original.

I hereby state that I fully understand the terms of this release.

Client Signature

Date

Witness Signature

Date

If client is under 18:

Parent or Guardian

Date

SDS 2/06