



STUDENT DISABILITY SERVICES

Permission to Release and Receive Confidential Information

I, _____ hereby request and authorize the following parties to exchange all 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.
Professors, Academic Advisors and
other relevant College Officials

This information includes: nature of disability, suggested teaching/learning strategies, nature of SDS tutoring sessions, and student's progress.

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 student is under 18:

Parent or Guardian Signature

Date

SDS 2/06