Consent to Exchange Confidential Information

Consent to Request Information

I, _____, give consent to the Coastal Bend College Office of Disability Services, to request medical and/or psychological evaluations related to my disability from state, federal, and medical agencies.

Student Name (Print)

Provider Information:

Name: _____ Phone: _____

Name: _____ Phone: _____

Authorization to Disclose Academic Information

I, _____, give permission to Coastal Bend College to share academic information (including mid-term grades) with state/federal agencies as needed.

Student Name (Print)

Authorization to Disclose Disability

I, _____, authorize the Office of Disability Services to disclose the nature of my disability (including actual diagnosis only on an as need basis) to faculty, staff, and/or upper administration.

Student Name (Print)

Student Rights

I understand that I may revoke consent at any time and that this revocation must be delivered to the Office of Disability Services in writing during standard business hours**. If I decide to not revoke my authorization, my authorization for disclosure will expire one (1) year from today.** I further understand that under the Federal Education Rights and Privacy Act of 1974, no disclosure of my records can be made without my written consent unless otherwise provided for legal, judicial, and safety purposes. I also understand that my disability documentation will be kept on file for five years and that I should keep a copy of any records pertaining to my disability.

_____ _____ _____

Student Name (Print) **CBC ID#** **Date of Birth**

_____ _____

Student Signature **Date**

_____ _____

Disability Services Coordinator **Date**

Office of Disability Services Email: Disability@coastalbend.edu Phone :(361) 354-2728 Fax: (361) 354-2727