



SAN DIEGO COMMUNITY COLLEGE DISTRICT
Disability Support Programs and Services

CONSENT FOR RELEASE OF INFORMATION
TO MIRAMAR COLLEGE



Student Information:

Releasing Party:

Name _____ Last First Middle	Educational Institution _____
K-12 ID#: _____	Address _____
SSN#(Last 4 digits) _____ Birth Date _____	_____
Maiden/other name _____ Last First Middle	Phone _____ FAX _____

I, the undersigned, consent to and request all appropriate persons and/or agencies/institutions to release information regarding myself to San Diego Miramar College for use in educational/vocational planning. All information will be kept confidential and maintained as a part of my records with the Disability Support Programs and Services office. I authorize the release of information to include one or more of the following records:

- ☐ K-12 School Psychologist's Report and Academic Assessment Results
- ☐ Audiology and Speech/Language Pathology Reports
- ☐ IEP or 504 Report
- ☐ Postsecondary Learning Disability Assessment Results

This authorization shall remain in effect until revoked in writing by the student.

Signature of Student

Date

Signature of Parent/Guardian
(Required for Student under 18 years of age; requesting from a K-12 institution)

Date

A PHOTOCOPY IS AS VALID AS THE ORIGINAL

Please return information to:

San Diego Miramar College
Disability Support Programs and Services
10440 Black Mountain Road
San Diego, California 92126-2999
Office (858) 536-7212 or (619) 388-7312
FAX (619) 388-7917
miradsps@sdccd.edu