SAN DIEGO COMMUNITY COLLEGE DISTRICT
Disability Support Programs and Services

CONSENT FOR RELEASE OF INFORMATION

Name _____ (Last / First / Middle)	Educational Institution _____
	Address _____
SSN# _____ Birth Date _____	_____
	_____
Maiden/other name _____ (Last / First / Middle)	Phone _____ FAX _____

I, the undersigned, consent to and request all appropriate persons and/or agencies or 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
- ❑ Postsecondary Learning Disability Assessment Results
- ❑ Audiology and Speech/Language Pathology Reports

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

_____ _____
Signature of Student Date

_____ _____
Signature of Parent/Guardian Date
(Required for Student under 18 years of age)

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 / TDD (619) 338-7301