Rogue Community College

DISABILITY SERVICES
Authorization for Release of Information

I authorize the mutual exchange of any and all pertinent information and records for the purpose of facilitating academic and employment planning. I understand that information about my case is confidential and protected by state and federal law. I understand that I am responsible for any deletions or additions to the list of individuals authorized to receive this information.

Name D.O.B. Student ID SSN (VA Requests Only)

Address Telephone

I authorize the following individuals or agencies:

_____ _____

_____ _____

_____ _____

to provide information to Rogue Community College**,** Disability Services, 3345 Redwood Highway, Grants Pass, OR 97527. (541) 956-7337 ~ Fax**: (541) 471-3550** ~ ORS 711.

Including records of: (*please circle yes or no*)

Yes	No	Family History	Yes	No	Employment/Unemployment
Yes	No	Testing and Educational Reports	Yes	No	Alcohol/Drug Treatment
Yes	No	Special Education Eligibility Statement/ School Psychologist Diagnostics/IEP	Yes	No	Medical/Psychiatric/Psychological or Mental Health Assessment/ Treatment Plan/Termination Summary*

* Alcohol/Drug, Mental Health and Medical reports include all aspects of diagnosis, treatment and prognosis. Educational reports include both behavioral and progress reports.

I agree that the agencies and/or individuals listed above may share and exchange information about my circumstances. The information received will be used to evaluate my situation and to plan for and coordinate services for me or for other purposes as specified.

This permission is good for one year or until:_____

I can cancel this at any time, but I understand that the cancellation will not affect any information that was already released before the cancellation. I approve the release of information only in those areas indicated above.

____ Client ____ Parent ____Guardian ____Legal Custody

Client Signature Date

Parent/Guardian/Legal Representative Date

RCC Representative Signature Date