

LAKE ERIE COLLEGE

STUDENT SUCCESS CENTER

Student Authorization for Release of Information

I, _____, give my permission to the Director, The Student Success Center to share information regarding the nature of my disability. I understand that this information will be released to faculty members and / or academic staff and / or the following agencies or individuals:

Agency / Faculty / Academic Staff / Individual

Student Initial / Date

The purpose of the release of information is to assist in the understanding of my documented disability and to support requests for coursework modification / accommodation and / or special services related to my documented disability.

The authorization is valid for the time I remain a student at Lake Erie College unless I rescind my permission in writing.

Student signature

Social Security Number

Date

Witness

FOR OFFICE USE ONLY
Copies:
<input type="checkbox"/> Student: _____
<input type="checkbox"/> Student file: _____