Disability Services
Release of Information Authorization

I, the undersigned, authorize ____ or its director, designee, or records department to release information contained in my records to the individual or organization listed below. This authorization will remain in effect until the student submits written notice terminating this consent to the Office of Disability Services.

Student Information

Name: __________________________________ Date of Birth: _________________

Social Security #: XXX – XX - __________

Name of organization to which disclosure is to be made:

Mott Community College
Disability Services – PCC 2280
1401 E. Court St, Flint, MI 48503
Phone: (810) 232-9181
Fax: (810) 232-9943

Information to be disclosed:

Purpose and need for such disclosure is to establish eligibility for support services to accommodate a disability and/or determine type of service(s) or accommodation(s) needed.

This information is required in order for the individual to receive academic accommodation(s). It is maintained in the office of The Learning Center and is kept confidential. This information does not become part of the student's permanent college record and is destroyed after a limited time. Mott Community College cannot be responsible for any incurred fees.

Student's signature ____________________________________ Date______________

Date Received: ___________________	Received By:_________________________________

Revised: 5/20/2015 9:12AM