NORTHEAST STATE COMMUNITY COLLEGE

ACCESSIBILITY SERVICES

RELEASE OF INFORMATION

I, _____, give my permission to the

Full Legal Name

Office of Accessibility Services at Northeast State to both obtain and share information/documentation from the following sources:

- ☐ Division of Rehabilitation Services: _____
  _____
- ☐ Medical Provider(s): _____
  _____
- ☐ Behavioral Health Provider(s): _____
  _____
- ☐ Educational Institution(s): _____
  _____
- ☐ Other: _____
  _____
  _____

I understand that this request for information is used only for the fulfillment of my educational needs. I have been informed that information about my disability is confidential.

I understand that in order for me to receive requested accommodations and services, it may be necessary for Accessibility Services to provide need-to-know information about me to other individuals, including administrators, faculty, and/or staff of Northeast State. I understand that I may modify or revise this Release of Information at any time.

Student Signature: _____ Date: _____

Student DOB: _____ NeSCC Student ID: _____