AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

RE:

Name:_____

Address:_____

City/State/Zip Code:_____

Birthdate:_____ Last 4 of SS#:_____

I authorize North Iowa Area Community College to:

☐ **Exchange with** ☐ **Disclose to** ☐ **Obtain from**

Name of Organization or Individual: _____

Mailing Address: _____

City/State/Zip: _____

Telephone #: _____ Fax #: _____

Information to be released (check Yes or No):

☐**YES** ☐**NO** Disability Status
☐**YES** ☐**NO** Evaluations and Notes/Summaries including Psychiatric/Psychological/Medical/Chemical Dependency
☐**YES** ☐**NO** School or Educational Information
☐**YES** ☐**NO** Accommodation Needs
☐**YES** ☐**NO** Other (specify) _____

I UNDERSTAND THAT:

- I have the right to revoke this authorization at any time by giving written notice to NIACC's EDUCATION Program.
- I understand the revocation will not apply to information that has already been released in response to this authorization.
- This authorization will permit two-way telephone communication and exchange of information electronically.
- I am entitled to a copy of this authorization once I have signed it.
- A photocopy or facsimile of this authorization is as effective as the original.

This authorization shall remain in effect (unless expressly revoked in writing) until graduation from NIACC or withdrawal from college.

_____ _____
Student Signature Date

_____ _____ _____
Parent/Guardian Signature (if underage or not the signee) Relationship to Client Date

Please return this form and the information requested to:

NIACC EDUCATE Program
500 College Drive
Mason City, IA 50401
Disability.Services@niacc.edu / Fax: 641.422.4108