CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize the following
(Print your name)

agencies to release/receive all information considered pertinent (psychological, medical academic, and financial) to/from the Special Student Representative, at Hagerstown Community College. Release of confidential information (type of accommodation required) is the only information that will be released to staff members who are involved in providing academic assistance and accommodations to you.

Faculty of Hagerstown Community College	**___yes**	**___no**
Learning Resource Center Personnel	**___yes**	**___no**
Financial Aid Office at Hagerstown Community College	**___yes**	**___no**
DORS	**___yes**	**___no**
Brook Lane Psychiatric Center	**___yes**	**___no**
Washington County Board of Education	**___yes**	**___no**
Coordinator of Academic Advisement	**___yes**	**___no**
Coordinator of Tutoring Services	**___yes**	**___no**
Annette Jeffers, L.C.S.W.-C	**___yes**	**___no**
HCC Library	**___yes**	**___no**
Other Agencies		
_____	**___yes**	**___no**
_____	**___yes**	**___no**
_____	**___yes**	**___no**

_____ _____ _____-_____-_____
(Student Signature) (Date) (Social Security Number)