

# CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Disability Services

Portland Community College

PCC must follow all applicable State and Federal laws (Family Educational Rights and Privacy Act, FERPA), rules and regulations that apply to student records, including communication with DS counselors and staff. Therefore, all information contained in the college records which is personally identifiable to any student shall be kept confidential and not released except: Upon express written consent of the student; In compliance with a judicial order or lawfully issued subpoena; To provide necessary information to school officials with legitimate educational interest; and or To notify appropriate officials in cases of health and safety emergencies.

\_\_\_\_\_  
(Student Name)

\_\_\_\_\_  
(Date of Birth)

**I hereby authorize Disability Services at Portland Community College to release information to:**

Name: \_\_\_\_\_ Agency or Relationship: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Two-Way Disclosure:** (must initial to authorize)

\_\_\_\_ I authorize the aforementioned person/agency to release information to Disability Services as noted above.

**Method of Disclosure:** (check all that apply)

\_\_\_\_ Verbal      \_\_\_\_ Written      \_\_\_\_ Fax      \_\_\_\_ E-Mail

**Specific Information to be Released:**

\_\_\_\_ Disability accommodations      \_\_\_\_ Disability diagnosis and related limitations

\_\_\_\_ Other (specify): \_\_\_\_\_

**Purpose of Disclosure:** \_\_\_\_\_

**This authorization is valid until:** \_\_\_\_/\_\_\_\_/\_\_\_\_

I understand I may revoke this authorization at any time in writing.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date