



Student disAbility Resource Center

1000 E. Victoria St., Carson, CA 90747 • Tel 310-243-3660 • Fax 310-928-7267 • sdrcc@csudh.edu

Consent for Release of Information

I hereby authorize the **Student disAbility Resource Center** to release to the person/ office, medical, psychological, and/or educational information pertaining to my needs named below:

Date: _____

From: _____

To: _____

I authorize the release and/or exchange of confidential information to include one or more of the following records:

- Verification of Disability
- Learning Disability Assessment (include Scores)
- Educational Records, including Progress
- Audiological & Speech/Language Pathology Reports
- Vocational Rehabilitation Plan
- Prescribed Medications & Dosages
- Psychological testing and evaluation
- Other (relative to Educational Limitations)

Print Student Name

Student Signature

Student I.D #

Student disAbility Resource Center Only:

Action Taken: _____

Authorizing Staff Signature: _____

Approved/ Denied: _____

Date Action Taken: _____

Appointment is needed. _____

No Record(s) Found _____