

Volunteer State Community College
Office of Disability Services
1480 Nashville Pike
Gallatin, TN 37066

Release of Information

Name _____

SS# _____

DOB _____

I hereby authorize and request _____ to release information related to:

_____ Therapy/counseling

_____ Psycho-educational test results

_____ Medical records

_____ Vocational evaluation

_____ Other

This information should be released to:

*Kathleen Sowell, M.S., CRC, LPE
Office of Disability Services
Volunteer State Community College
1480 Nashville Pike
Gallatin, TN 37066
Phone 615-230-3472 Fax 615-230-4808*

Purpose of disclosure: To verify the student's disability in order to determine accommodations. These accommodations allow the student to receive services while attending Volunteer State Community College. These accommodations are reasonable, appropriate, and necessary for the student's academic success.

I understand this information will be kept confidential and will not be further released by the Office of Disability Services without my consent. I understand I may revoke this authorization at any time.

Name (please print) _____

Date _____

Signature _____

Date _____

This release shall remain in effect for no greater than 60 days.