**Student Accessibility Services**

**Marian Hall, 2C17**

**Phone: 614-234-4393**

**Fax: 614-234-5979**

**Release of Information Authorization**

This form must be completed in its entirety and include wet signatures (no electronic) for Student Accessibility

Services to release information.

I,

(Print Full Name)

, authorize Mount Carmel College of Nursing’s

Student Accessibility Services department to release information to:

Name/Business/MCCN Department:

Via the following method: (check all that apply)

Mail to this address:

Fax to this number:

To myself (I will pick up at SAS)

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent for the following information to be released: (check all that apply)

 Psychological Evaluation

 Medical documentation

 Accommodation History at Mount Carmel College of Nursing

 History of Accommodations (i.e.; High School IEP or 504, etc.)

 Other (Please Specify):

Specify purpose for release:

This release is valid for one year from the date of my signature unless an alternate expiration date is specified. Either initial verifying you understand this release is valid under the terms stated above, or indicate an alternate

expiration date here:

. I understand the nature of the information referred to in this release is

confidential and that I may revoke this authorization at any time in writing.

Student Signature and Date Witness (Print Name & Association)

Student ID # Witness Signature & Date

Student Contact #