Disability Support Services

Consent to Release Confidential Information

RELATIONSHIP TO STUDENT

☐ Myself ☐ Parent or Legal Guardian ☐ Agent with Power of Attorney

STUDENT INFORMATION

Name _____ SID _____

Phone _____ DOB _____

PROVIDER INFORMATION

PROVIDER 1: Name _____ Title _____

Agency _____ Phone _____

PROVIDER 2: Name _____ Title _____

Agency _____ Phone _____

Additional Providers listed on the back of this page? Yes No

RECIPIENT INFORMATION

Please send information to: Disability Support Services
Lake Washington Institute of Technology
11605 132nd Ave NE
Kirkland, WA 98034

Phone: (425) 739-8166
Fax: (425) 739-8275

EXTENT OF INFORMATION TO BE DISCLOSED

- All relevant medical/psychiatric data which documents the diagnosis, history and date of onset, treatment, and functional limitations created by this person's disability/ies.
- All psychological/educational testing which documents a learning disability (including Woodcock-Johnson Revised Full Battery, WISC/WAIS-R, I.E.P.'s, report that describe specific services needed, and any recommended strategies or accommodations).

PURPOSE OF DISCLOSURE OF INFORMATION

To determine eligibility for services and accommodations in the post-secondary education setting (as outline by Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990).

This release is given by the undersigned patient/student. Your full cooperation in this request is respectfully requested.

_____

Signature **Date**

ADDITIONAL PROVIDER INFORMATION

PROVIDER 3: Name _____ Title _____

Agency _____ Phone _____

PROVIDER 4: Name _____ Title _____

Agency _____ Phone _____

PROVIDER 5: Name _____ Title _____

Agency _____ Phone _____

PROVIDER 6: Name _____ Title _____

Agency _____ Phone _____

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