Disabled Student Programs & Services
3000 Campus Hill Drive | Room 1615, Livermore, CA 94551

AUTHORIZATION TO RELEASE INFORMATION

Student Name: ____ W#: ____________________

Date of Birth: _______________________ Phone Number: _____________________________

Address: ____

By signing this form, I am authorize the Las Positas College Disabled Student Programs & Services (DSPS) office to share or obtain the following information with the individual and/or office named below:

I wish to:

- ☐ Release my Las Positas College DSPS documents to the party named below
- ☐ Have my information released to myself
- ☐ Have my information released, scanned, and emailed to Las Positas College DSPS at lpc-dsps@laspositascollege.edu

The information I would like released is/are the following:

- ☐ Disability Verification
- ☐ Academic Accommodation Plan (AAP)
- ☐ DSPS Application for Services
- ☐ IEP/504 Plan/LD Testing/Psychological Evaluation/Speech Evaluation
- ☐ Medical or psychological records
- ☐ Other: ____

Please provide complete contact information for the individual or office to be contacted.

Name: ____

Address: ____

Phone Number: _______________________ Fax Number: _______________________

Email: ____

- This consent shall remain in effect for the duration of the current academic year as noted by the signed consent date below.
- Students may rescind this authorization at any time by making requests known in writing.
- It may take up to seven (7) business days to process this request.
- Students must fill out separate requests for each individual/office authorized by this consent.
- A valid photo identification is required to process all requests.

☐ *By checking this box I certify that the above information is true to the best of my knowledge and that I am the individual named at the top of the form.*

Student Signature: ________________________________ Date: ___________