SIMMONS COLLEGE
DISABILITY SERVICES
Main Campus Building, Room E-108
300 The Fenway, Boston, MA 02115
p. 617.521.2474 f. 617.521.3079

Authorization for Release of Confidential Information

SIMMONS ID#

___ ___ ___ ___ ___ ___

NAME ____

CELL PHONE (_________) ____________________________ EMAIL ____

I, ____, make the following authorizations regarding the release of information pertaining to my disability, documentation, and disability related needs for the purpose of assisting me in my academic program, as well as in determining reasonable accommodations at Simmons College.

❒ ***Parent, Family Member, Legal Guardian***

Name____

Address ____

Phone Number ____

❒ ***Licensed Healthcare Professional***

Name____

Address ____

Phone Number ____

❒ ***OTHER – Please indicate below (i.e. release information to college/university)***

Name ____

Address ____

Phone Number ____

I understand that I may revoke this release at any time. By signing this release, I understand that the Disability Services Office will not contact these individuals, but may release information to those noted if applicable. This release will automatically expire one year from today's date.

Student Signature ____ Date ______________________