VIRGINIA WESTERN
COMMUNITY COLLEGE

WE'LL TAKE YOU THERE

OFFICE OF DISABILITY SERVICES

AUTHORIZATION TO RELEASE INFORMATION

I, _____, _____, request and/or authorize the Office of
PRINTED NAME DATE OF BIRTH

Disability Services (ODS) at Virginia Western Community College (VWCC) to release/disclose/discuss the following:

INFORMATION TO BE RELEASED/DISCLOSED: (check all that apply)

☐ **Academic Information** ☐ **Disability Information** ☐ **Financial Aid Information**

AUTHORIZED TO RELEASE AND DISCLOSE INFORMATION TO:

1. Name: _____ 2. Name: _____

Relationship: _____ Relationship: _____

Phone: _____ Phone: _____

By signing below, I consent to the release of the information above to the individual(s) listed above:

_____
Student Signature Date

In order to have information released via phone, fax, or e-mail to the Party to Whom Information will be Released listed above, a personal identification number (PIN) of at least four-digits must be assigned by the student. The Party to Whom Information will be Released must identify this PIN number to receive student information. PIN _____

This consent shall remain in effect through (choose one):

- ☐ Entire duration of enrollment with Virginia Western Community College
- ☐ Academic Year or Term (specify) _____
- ☐ Until graduation from high school. Provide graduation date _____

COMMENTS:

_____

_____