



Authorization to Release and/or Obtain Client/Patient/Student Information
Scottsdale Community College
Disability Resources & Services (DRS)

Name: _____ Date of Birth: _____ Soc. Sec. #: _____

Address: _____

City: _____ State: _____ Zip: _____

I request that my health and/or educational and/or mental health records be released

TO FROM:
(Circle one)

Name: _____ Attn: _____

Address: _____

City: _____ State: _____ Zip: _____

TO FROM:
(Circle one)

Scottsdale Community College
Disability Resources and Services
9000 E. Chaparral Road, SC 144
Scottsdale, AZ 85256

Office: 480.423.6517
Fax: 480.423.6377

The information to be released shall include the following:

- Entire Record
- Special educational record including PsychoEducational Evaluation and IEP
- Evaluation results and diagnoses (psychological/mental health)
- Medical diagnosis, impact of disability and medication
- Other reports: _____

I hereby release the college from all legal liability that may arise from the information requested. I hereby certify that this request has been made freely, voluntarily and without coercion. Information given above is accurate to the best of my knowledge and I understand that I may revoke this authorization at any time. Faxed copies of this release from are as valid as the original.

Student's Signature

Date

Witness

Date

Third Party Restrictions:

Information contained herein is for the intended purpose and is not to be used for any other purpose or released to any other person or organization without written consent of the student whose name appears herein.