BRUNSWICK
COMMUNITY COLLEGE

Consent for Release of Confidential Information

Name of Student_____ SS #_____

I authorize the following individuals/organizations to share information in my files:

____ BCC Faculty/Staff
____ Parent(s) _____
____ Vocational Rehabilitation
____ Other_____

This information may include the following:

____ Psychological Evaluation/Testing Information
____ Coordination of Services with Vocational Rehabilitation
____ Disability information and functional limitations
____ School related information
____ Other_____

I understand that my records are confidential and cannot be disclosed without my written consent. This consent can be revoked at any time.

_____ _____
Student Signature Date

_____ _____
Witness Signature Date