



Release of Information

Full Name: _____

900#: _____

Date of Birth: _____

**Please sign and check the appropriate release box below
AND submit form with a picture ID**

Student Signature: _____ Date: _____
This authorization will remain in effect until revoked in writing.

RELEASE OF INFORMATION FROM SAC TO SPELMAN FACULTY AND STAFF - I authorize Student Access Center to release and/or discuss pertinent information concerning my disability, accommodations, and/or current academic status at Spelman with appropriate faculty, staff, and administrators.

RELEASE OF INFORMATION FROM SAC TO OTHER AGENCIES - I authorize Student Access Center to release the designated information to the following person, organization or agency:

Any pertinent disability information

Specific information listed here: _____

Name/Organization: _____

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

RELEASE OF INFORMATION FROM OTHER AGENCIES TO SAC-I hereby request and authorize you to release to Student Access Center at Spelman College any information from your records which bears on the medical or health conditions and/or educational development pertaining to me. All information will be kept confidential and maintained as part of my records with SAC at Spelman College.

Name of Physician/Specialist/Agency providing verification of disability:

Street Address: _____

City/State/Zip: _____

Phone Number: _____ Fax Number: _____

Email: _____