STUDENT SUPPORT SERVICES
DISABILITY AND CAREER SERVICES

GEORGIA HIGHLANDS COLLEGE
DISABILITY SUPPORT SERVICES

GEORGIA HIGHLANDS COLLEGE GHC UNIVERSITY SYSTEM OF GEORGIA 1970

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

In signing this statement, I _____, ID# _____, hereby authorize the release of information described as follows:

_____

_____

to Georgia Highlands College Student Support Services director or affiliated staff member.

I understand this allows information to be supplied to any Georgia Highlands College faculty member, staff member, and/or Regents Center for Learning Disorders staff member on a need to know basis. I understand providing this information is used only to substantiate the need for accommodations and the nature of accommodations required. I understand this authorization remains in effect for each term that I am a student at Georgia Highlands College unless I revoke it in writing.

_____ _____
Student Signature Date

_____ _____
Accepted By Date

Addendum:

I, _____, grant permission for SSS staff to speak with the individual(s) named below, on my behalf, regarding disability support services.

Name: _____ Relationship: _____

_____ _____
Student Signature Date

_____ _____
Accepted By Date