STUDENT SUPPORT SERVICES
CAREER, COUNSELING, AND DISABILITY SUPPORT

GEORGIA HIGHLANDS COLLEGE
DISABILITY SUPPORT SERVICES

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION TO OTHER AGENCIES

Student: _____ ID #: _____
Email: _____ Phone: _____
Reason for request: _____

In signing this statement, I hereby authorize the release of information by Student Support Services, described as follows:

- Disability records/accommodations
- Other:_____

To the following agency/institution:
Agency/Institution Name:_____
Dept/Contact Person: _____
Fax: _____ Phone: _____

I understand this allows information to be supplied for the purpose of making a referral for services. I understand sharing this information is only to substantiate the need for services by another agency. 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 SSS Staff Member Date