**Consent for Release of Confidential Information:**

**I hereby give my permission for Disability Services Office to release or obtain information to or from other professionals, on and off campus, relevant to the impact of my disability concerning my education. I understand sharing of information is necessary in order to assist me in the pursuit of my educational/career goals. This authorization shall remain in effect during my enrollment at Forsyth Technical Community College or until revoked in writing by me. I have been informed that signing this form is voluntary.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Student’s Full Name (printed)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disability Services Office Counselor’s Signature Date**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Disability Services Office Counselor’s Full Name (printed)**