



## Office of Student Accommodations

### AUTHORIZATION TO RECEIVE AND RELEASE INFORMATION

Your disability record constitutes privileged information that is protected by the laws of the State of Texas and may contain information protected under Federal confidentiality regulations. You may revoke this consent through written notice but it will not apply to action that has been taken prior to the revocation.

I, \_\_\_\_\_, TC ID # \_\_\_\_\_  
First Name Middle Name Last Name

authorize the Temple College Office of Accommodations and

\_\_\_\_\_ Faculty \_\_\_\_\_ DARS/DBS  
\_\_\_\_\_ Department Heads \_\_\_\_\_ TC Counseling personnel  
\_\_\_\_\_ Academic Chairs \_\_\_\_\_ Others: parents, spouse, etc.

\_\_\_\_\_  
Name Relationship Phone Number

to release and exchange with each other, in oral and/or written reports, information concerning:

\_\_\_\_\_ Documented disability \_\_\_\_\_ Academic Accommodations  
\_\_\_\_\_ Results of testing/evaluation \_\_\_\_\_ Participation in counseling  
\_\_\_\_\_ Other: \_\_\_\_\_

I understand that no disclosure of my records can be made without my written consent unless otherwise provided for in legal statutes and judicial decisions.

Date: \_\_\_\_\_

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Signature of Witness  
Office of Student Accommodations

I understand I may revoke this consent in writing at any time, but may not act to revoke consent on action already taken. This release expires when I am no longer a registered student and/or one year from the date of signature, whichever comes first.