Alfred State
SUNY College of Technology

Student Disability Services

The Learning Center
Student Development Center
Alfred, NY 14802
(607) 587-4122

Consent for Release of Confidential Information

I, _____, freely give my consent and authorize

_____

(name and address of the high school, college, or medical facility)

to release to the counselors of students with disabilities at Alfred State the following appropriate confidential information: academic, medical, diagnostic testing information, Committee on Special Education reports, Psychological Educational Evaluation, and Individualized Educational Plan (IEP).

This authorization is restricted as follows: this consent will become null and void at the conclusion of my enrollment at Alfred State, unless revoked by me at an earlier time.

I understand that this information is to be used only to arrange services for me, is confidential, and is protected from unauthorized disclosure.

I also authorize the counselors of students with disabilities to share this information with the personnel listed below when appropriate:

1. Academic staff/faculty
2. Counseling staff
3. Director, Health and Wellness Services
4. Director, Residential Life & my residence hall coordinator
5. University Police

*6. Director, Physical Plant

*7. Auxiliary Campus Enterprises and Services

I understand that these personnel will maintain the confidentiality of this information and will not release it to any other person without my signed consent.

_____ _____

Date Signature

I am the parent or guardian of _____, a person under the age of 18. I hereby give my consent to the release of confidential information on the above-stated terms.

_____ _____

Date Signature

*for physical/mobility purposes

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