Blue Ridge – Student Accessibility Services
180 W. Campus Drive, Flat Rock, NC 28731
Phone (828) 694-1813 • Fax (828) 696-2446

CONSENT TO RELEASE/DISCLOSE INFORMATION - BLUE RIDGE STUDENT ACCESSIBILITY SERVICES

I, ___________________________, DOB: ____/____/______ authorize Blue Ridge Community College Student Accessibility Services (SAS) to disclose to/receive information from:

☐ Blue Ridge Faculty & Staff
☐ Parent/Family ____
☐ Other ____

the following specific information: Mutual exchange of information for educational planning & Blue Ridge SAS service provision. Information to include name, address, phone number, social security number, diagnoses, medical/mental health data, diagnostic evaluations, educational records, disability related information.

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent. I understand I may revoke this consent at any time except to the extent that action has been taken.

____
Signature of Student

____
Signature of Parent, Guardian, or Authorized Representative, (when required)

____
Date

Confidential

The information is provided by the Student Accessibility Services Office for the purpose of educational planning. We appreciate the respect for the student's confidentiality and the understanding that state and federal laws prohibit the release of this information to any other person or agency or for use in any manner for any other purpose. Students with disabilities are eligible for appropriate services stipulated under Section 504 of the Rehabilitation Act of 1973 and the Americans with Disabilities Act of 1990. The Student Accessibility Services Office has received all necessary documentation that substantiates the student's need for academic accommodations.

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REVOCATION SECTION

I do hereby request that this authorization to disclose health information of

__________________________ signed by ____
(Student Name) (Name of Person Who Signed Authorization)

on ____________________ be rescinded, effective _______________. I understand that any
(Enter Date of Signature) (Date)

action taken on this authorization prior to the rescinded date is legal and binding.

____________________________ _________ _______________________ ______
(Signature of Student) (Date) (Signature of Witness) (Date)

_______________________________ ______ ____
(Signature of Personal Representative) (Date) (Personal Representative Relationship/Authority)

VERBAL REVOCATION SECTION

I do hereby attest to the verbal request for revocation of this authorization by

_______________________________________ on ________________________.
(Name of Student or Personal Representative) (Date)

The student or their personal representative has been informed that any action taken on this authorization prior to the rescinded date is legal and binding.

____________________________ ________ ____________________________ ______
(Signature of Staff) (Date) (Signature of Witness) (Date)

Confidential
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