Colby

OFFICE OF THE DEAN OF STUDENTS
4250 Mayflower Hill
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Authorization to Release & Exchange Information

Name: ____ SS#______-______-______ DOB _____/_____ /_____

I authorize information to be released (please initial each authorization):

_____ FROM Colby College TO: ____

Address:____ Phone:________________

_____ TO Colby College FROM: ____

Address: ____ Phone:________________

Information Requested:

_____ Copy of my disability documentation sent to: ____

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_____ Information and recommendations that will help in arranging for the provision of reasonable accommodations for me.

_____ Information concerning my use of, and the effectiveness of, those accommodations that I have requested.

_____ Supplemental relevant information regarding disability documentation and/or recommended accommodations.

_____ Other: ____

This information is to be used in determining my eligibility to receive accommodations and to identify reasonable accommodations.

I understand this release expires once I graduate. I understand I have the right to revoke this release at any time. I understand if I wish to revoke the release, I must do so in writing. I understand that if I limit the release of information, I may not be eligible for accommodations.

Name (print):____

Signature: ____ Date: ________________