CALHOUN
COMMUNITY COLLEGE

FOR SDS/ADA OFFICE USE ONLY

Date received: _____ by: _____

Date sent: _____ by: _____

Student Disability Services/ADA
P.O. Box 2216 / Decatur, AL 35609
Phone: (256) 306-2630 / Fax: (256) 260-2447

REQUEST TO RELEASE INFORMATION

I, _____ (_____),

FULL NAME (FIRST, MIDDLE, LAST) ID NUMBER

hereby give authorization to **Student Disability Services/ADA of Calhoun Community College** to release a statement of the academic adjustments and modifications I receive/received at Calhoun Community College to:

_____

NAME OF PERSON, AGENCY, SCHOOL, ETC.

_____

ADDRESS

_____

PHONE NUMBER/FAX NUMBER (IF KNOWN)

I further understand that by signing this written request, Calhoun Community College cannot be held liable for the exchange or release of such information.

DISCLAIMER: By typing your name below, you are signing this application electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this application.

Signature: _____

Date: _____