



**SAN DIEGO COMMUNITY COLLEGE DISTRICT
Disability Support Programs and Services**

**CONSENT FOR RELEASE OF INFORMATION
TO MIRAMAR COLLEGE**



Student Information:

Releasing Party:

Name _____ Last First Middle K-12 ID#: _____ SSN#(Last 4 digits) _____ Birth Date _____ Maiden/other name _____ Last First Middle	Educational Institution _____ Address _____ _____ _____ Phone _____ FAX _____
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I, the undersigned, consent to and request all appropriate persons and/or agencies/institutions to release information regarding myself to San Diego Miramar College for use in educational/vocational planning. All information will be kept confidential and maintained as a part of my records with the Disability Support Programs and Services office. I authorize the release of information to include one or more of the following records:

- K-12 School Psychologist's Report and Academic Assessment Results
- Audiology and Speech/Language Pathology Reports
- IEP or 504 Report
- Postsecondary Learning Disability Assessment Results

This authorization shall remain in effect until revoked in writing by the student.

Signature of Student

Date

Signature of Parent/Guardian
(Required for Student under 18 years of age; requesting from a K-12 institution)

Date

A PHOTOCOPY IS AS VALID AS THE ORIGINAL

Please return information to: San Diego Miramar College
Disability Support Programs and Services
miradsps@sdccd.edu