



Consent for Release/Exchange of Information

Name _____ Social Security Number _____

I, the undersigned, authorize the professional exchange of medical records and/or testing materials and information between the following:

The Office of Disability Support Services
 310 University Center
 Adelphi University
 Garden City, NY 11530

and:

- Adelphi University, Health Services Center, Waldo Hall (main floor) Garden City, NY
- Adelphi University, Student Counseling Center, 310 University Center, Garden City, NY
- Derner Institute – Psychological Services Center, Adelphi University, Hy Weinberg Center, Garden City, NY
- Adelphi University, Program for College Students with Learning Disabilities, Eddy Hall (lower level), Garden City, NY 11530
- Adelphi University Academic Services and Retention, 303 Levermore Hall, Garden City, NY
- Adelphi University Faculty: _____
- Other Professional Office or Agency: _____

Need for Disclosure: The provision of documentation of a physical or learning disability in order for the student to receive special accommodations provided by the University as well as coordination of accommodations with administration, faculty and staff.

I understand that such disclosure is bound by regulations governing the confidentiality of medical/psychological records and any additional disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I also understand that I have the right to cancel my permission to release information at any time before it is released.

 Signature of Student Date

 Signature of Parent/Guardian Date
(Required if the student is under 18 years of age)

 Name of Student *(Please print)*

 Name of Parent/Guardian *(Please print)*

 Date of Birth *(mm/dd/yy)*

 Relationship to Student

 Witness Date

 Professional Position