Paul Smith's College
THE COLLEGE OF THE ADIRONDACKS

Consent for Periodic Release of Information

I, _____, HEREBY GIVE permission

To: Roxanne McCarty
Learning Specialist
Center for Accommodative Services
Paul Smith's College

to discuss or share information regarding my disability with Paul Smith's College professors and staff as often as necessary to design and implement reasonable accommodations and services. I understand that the information released is confidential and protected from disclosure. I also understand that I have the right to cancel in writing my permission to release information at any time, except to the extent that it has already been acted upon.

From: Name: _____

Address: _____

_____

_____

Date of Birth: _____

Signature: _____

Date: _____

I hereby request my consent authorization be withdrawn.

Signature_____Date_____