

AUTHORIZATION TO RELEASE INFORMATION

Name: _____ / _____ / _____ Date: ____/____/____
Last First Mi

TO:

- | | |
|--|--|
| <input type="checkbox"/> TMCC Staff/Instructors/Tutors | <input type="checkbox"/> Psychological |
| <input type="checkbox"/> Washoe County School District | <input type="checkbox"/> Medical Personnel |
| <input type="checkbox"/> Bureau of Vocational Rehabilitation | <input type="checkbox"/> Parents/Family |
| <input type="checkbox"/> NSHE Institutions | <input type="checkbox"/> Other: _____ |

I am aware that a disability fact sheet will be sent to my instructor(s) _____
Student Initials

FR: Disability Resource Center, Truckee Meadows Community Collage

RE: Release of Student Information/Records

The student whose name and signature appear below has authorized the release of his/her records to the Disability Resource Center of Truckee Meadows Community College for the purpose of determining program eligibility and/or documentation of services received from your agency.

The purpose of this authorization is to release information to determine eligibility to receive requested academic support services through the Disability Resource Center. Such requested support services include the following: specialized test administration, tutoring, scribe, readers, alternate textbooks, note taking, or other individualized services appropriate to meet the student's needs while enrolled at Truckee Meadows Community College.

Student Signature

_____/_____/_____
Date

Witness Signature

_____/_____/_____
Date

Year	Initial	Year	Initials	Year	Initials

Disability Resource Center
 Red Mountain Building 315
 7000 Dandini Boulevard
 Office: 775-673-7277
 Web: www.tmcc.edu/drc