Student Disability Services/ADA

P.O. Box 2216 • Decatur, AL 35609

Phone: (256) 306-2630 Fax: (256) 260-2447

For SDS/ADA Office Use Only

Date Received: ______________ By: _________

Date Sent: __________________ By: _________

REQUEST TO RELEASE INFORMATION

I, ____ (______________________)

FULL NAME (FIRST, MIDDLE, LAST) C 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.

____ ____________________

STUDENT SIGNATURE DATE

Rev 5/17