#### GalCollegeLogo

#### CONSENT FOR RELEASE OF CONFIDENTIALITY

I, , give permission for a representative of Galveston College

(Printed Name)

Counseling Department to share and receive written and/or verbal information regarding special needs assessment, diagnosis, recommendations, treatments, personal issues, grades and/or other information listed below. The purpose of releasing this information is to help me gain assistance and/or special accommodations while attending Galveston College. This release of confidentiality is effective beginning

Month: Day: Year: and expires on Month: Day: Year:

**Person/Agency Information may be released to:**

Social Service

Person’s Name Organization or relationship to student

Higher Education

Institution Person’s Name Organization or relationship to student

High School

Person’s Name Organization or relationship to student

Parent/Guardian

Person’s Name Organization or relationship to student

Other

Person’s Name Organization or relationship to student

**Information requested:** ***Disability documentation needs to be on letterhead and include diagnosis, functional limitations and suggested accommodations.***

Verbal Communication  Treatment Plans  All Written Records

Lab Reports  IEP/Special Ed Records  Other:

Medical Records  Psychological/Psychiatric

Evaluations/Results

*The above requested information will be used for general assistance, academic planning and/or accommodation purposes. I understand that my records are protected under regulations and laws and cannot be disclosed without this written consent unless legally ordered. I also understand that I have the right to revoke this consent for release of information at any time.*

**Student Signature: Date:**

**Galveston College Special Services Office**

**4015 Ave Q, Galveston, TX 77550**

**Phone: 409-944-1220 Fax: 409-944-1501**