CALHOUN
COMMUNITY COLLEGE

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