Center for Access and Assistive Technology

Campus Center, Room 130
(518) 629-7154 T.D.D. (518) 629-7596 Fax (518) 629-4831

RELEASE AUTHORIZATION

I, _____, (DOB)_____, give the Center for Access and Assistive Technology permission to release information regarding my disability to the following:

A. Offices associated with Hudson Valley Community College, Admissions Office, Health Offices, Professors, Financial Aid Office, Registrar, Counseling Center, Tutorial Services, Testing Office, Academic Advisors, Adult Career and Continuing Education Services-Vocational Rehabilitation (ACCES-VR), Commission for the Blind and Visually Handicapped, Veterans Administration and any other sponsoring agency.

B. In addition, I authorize the Center for Access and Assistive Technology to obtain information from the following contacts, related to my disability that may assist them in providing services to aid my education at Husdon Valley Community College.

Doctor:_____ Phone Number:_____

Address:_____

Parent or Guardian:_____ Phone Number:_____

Address:_____

Therapist:_____ Phone Number:_____

Address:_____

Other (Please specify):_____ Phone Number:_____

Address:_____

I further release and hold harmless the Center for Access and Assistive Technology and Hudson Valley Community College from any and all liability that may result from the release and/or use of such information.

Student Signature:_____ Date:_____

HVCC Student ID # H00_____ HVCC Student e-mail:_____

Home Phone #:_____ Cell Phone #:_____