

## Access Services Release of Information

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I hereby give Access Services permission to share information with the following persons/agencies during my enrollment at South Puget Sound Community College:

All Agencies and/or persons with a legitimate educational need to know

**Or, check specific groups below with whom we may share information:**

All Faculty

Specific Faculty Only (please list): \_\_\_\_\_

Class Schedule for Campus Security Office

Other SPSCC Personnel (please list): \_\_\_\_\_

Parents(s) (please state name(s)): \_\_\_\_\_

Previous Educational Institutions

Medical / Counseling Facilities

Recording for the Blind and Dyslexic

Department of Vocational Rehabilitation

Labor and Industries

Other: \_\_\_\_\_

*I understand that such disclosure is bound by regulations governing the confidentiality of medical/psychological records and any additional disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part. I also understand that I have the right to cancel my permission to release information at any time before it is released.*

Student Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Print Name: \_\_\_\_\_

If you have questions please call:  
Access Services

PHONE: (360) 596-5306 E-mail: [access.services@spscc.edu](mailto:access.services@spscc.edu)