

CONSENT TO RELEASE INFORMATION

**TO: Honolulu Community College
Student ACCESS**

FAX No: (808) 844-2391

I hereby request and authorize you to release the information and records designated as follows:

_____ Disability Documentation (medical diagnosis, physical limitations, psycho-educational assessment, and recommendations for accommodations in educational setting, if available):

_____ I give my permission to have you discuss my disability, educational
(initial) program, and progress, and goals for purposes of planning and coordinating appropriate support services with _____ of

(Agency) (Phone Number)

Please mail these disability documents directly to:

**Honolulu Community College
Student ACCESS
874 Dillingham Blvd. 5-107B
Honolulu, Hawaii 96817
Attn: Wayne Sunahara
Disability Specialist**

I understand that this consent will aid in the process of obtaining disability documents required for registration or services.

Last Name, First Name M.I. (Print)

Date of Birth

School I.D. Number

Daytime Phone Number

Parent's/Guardian's Signature for Minors

Email Address

X

Student Signature Date

Student ACCESS Office notes: Mailed successfully ___/___/___ at ___:___ am/pm
Other Notes: