Delgado COMMUNITY COLLEGE

CONSENT TO RELEASE INFORMATION
Waiver of Confidentiality Form for Person with Disability

All information that has been gathered on a person is personal and private, and you are not required to release this information. Such information cannot be released without authorized written permission, except as required by law.

PERSON WITH DISABILITY:

Name: (1)_____ Date of Birth: ____/____/____

Address: (1)_____

City:_____ State:_____ Zip Code:_____

AUTHORIZED REPRESENTATIVE (If Applicable):

Name: (2)_____

Address: (2)_____

City:_____ State:_____ Zip Code:_____

I understand that the information in the record of the person above (1) is considered personal and private. However,
I GIVE MY PERMISSION FOR:

Name: (3)_____

Address: (3)_____

City:_____ State:_____ Zip Code:_____

TO RELEASE TO:

Name: (4)_____

Address: (4)_____

City:_____ State:_____ Zip Code:_____

***THE FOLLOWING SPECIFIC INFORMATION*:** (5) _____

TO BE RELEASED FOR THE SPECIFIC PURPOSE(S) OF: (6) _____

My permission to release this information will expire: (7)_____

I understand that my permission may be cancelled at any time except when the information has already been released.

_____ _____

(8) Signature of Person with Disability (Date) (9) Witness (Date)

For Authorized Representative Only (If Applicable)--
I understand that my permission to release this information may be cancelled at any time except when the information has already been released. The undersigned certifies that he/she is the authorized representative of the person listed above and has the authorization to sign on behalf of the person, either by court order, or by operation of law.

_____ _____

(10) Signature of Authorized Representative (Date) (11) Witness (Date)