LOS ANGELES TRADE-TECH
LATTC
A Community College

Disabled Student Program & Services
400 W. Washington Blvd., Los Angeles CA 90015
(213) 763-3773 TDD (213) 763-5375

Consent for Release of Information

To:_____ Student's Name:_____

_____ Student ID #: _____

_____ Birth Date: _____

(**Please print the name and address of your doctor or the agency in the above space)**

I hereby consent to the release of information from my records (in accordance with the Federal Family Education Rights and Privacy Act of 1974, or other laws, regulations, or policies) to LATTC Disabled Student's Program, in order that they may determine my eligibility for and need or special services. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

_____ Verification of Disability
_____ Psychological testing and evaluation results
_____ Learning Disability assessment
_____ Audiology and speech/language pathology reports
_____ Vocational rehabilitation plan
_____ Prescribed medications and dosage
_____ Educational records, including progress made
_____ Other _____

_____ _____
Signature of Student Date

I further give permission for the DSP&S staff professionals to discuss my educational situation with other professionals, including Department of Rehabilitation Counselors, and Instructors on campus, who have a legitimate educational need to know. This authorization shall remain in effect during my enrollment or until revoked by me in writing.

_____ _____
Signature of Student Date

_____ _____
Signature of Parent or Guardian Date
Required for students under 18 years of age

A PHOTOCOPY OF THIS DOCUMENT IS A VALID AS THE ORIGINAL
*Materials available in alternative media format upon request