INDIAN HILLS COMMUNITY COLLEGE

Student Disability Services
Release of Confidential Information

Student's Name: _____

IHCC ID #_____ Birthdate: _____

Permission for IHCC Instructors/Professors & Appropriate Staff

I hereby give permission to the IHCC Student Disability Services Coordinators to release confidential information from my file in order to set up classroom accommodations and/or services connected to accessibility and my specific disability. I understand that I must provide the required documentation of my disability in order to receive accommodations and services.

_____ _____
(Student's Signature) (Date)

Permission for Family, Agencies, and Others

I hereby give permission to the IHCC Student Disability Services Coordinators to release confidential information on my behalf to the following:

☐Parents/Guardians: _____

☐Vocational Rehabilitation Counselor: _____

☐Job Corps: _____

☐Other: _____

I understand that this authorization is in effect until I complete an updated form.

_____ _____
(Student's Signature) (Date)

COMPLETED FORMS MAY BE FAXED TO (641) 683-5206
ATTN: IHCC Disability Services Office