COLLEGE of CENTRAL FLORIDA
–an equal opportunity college–

AUTHORIZATION FOR RELEASE OF INFORMATION

CF ID No.: _____

Legal Name: _____
Last First Middle (complete) Jr., etc.

Birth Date: _____
MM/DD/YY

I authorize the exchange of pertinent information concerning my disability to the necessary administration, faculty and staff members of the College of Central Florida. The Accessibility and Counseling Center determines who should receive this information. I understand that this information will be used to arrange for appropriate accommodations to meet course requirements or to participate in other college activities.

In addition, I authorize the Accessibility and Counseling Center at the College of Central Florida to obtain information from and/or release information to (check all that apply):

- ☐ Division of Vocational Rehabilitation
- ☐ Division of Blind Services
- ☐ Worker's Compensation
- ☐ Center for Independent Living

Other (specify):
(e.g., Parents/Guardian)

Name: _____
Address: _____
City, State, ZIP Code: _____
Telephone No.: _____
Email: _____

I understand and have discussed with the Accessibility and Counseling Center staff that all information concerning disability documentation remains confidential, except for appropriate service providers and members of the college staff on need-to-know basis.

_____ _____
Student Signature Date: MM/DD/YY

Return this form to CF Accessibility and Counseling Center, Bryant Student Union, Room 204, Ocala Campus, 3001 S.W. College Road, Ocala, FL 34474-4415, or email to disability@CF.edu. Call 352-854-2322, ext. 1209 for further information.