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 College of Central Florida. The office of Disability Services 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 exchange of pertinent information, including medical and psychological evaluations, accommodations and academic status with the following outside agencies:

Check all that apply.

- ☐ Division of Vocational Rehabilitation
- ☐ Division of Blind Services
- ☐ Worker's Compensation
- ☐ Center for Independent Living
- ☐ School Name: _____ Years Attended: _____
- ☐ Other Agency Name: _____
  Telephone No.: _____
- ☐ Other Individual (name and relationship to you): _____
  Telephone No.: _____

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

_____ _____
Student Signature Date: MM/DD/YY

Return this form to CF Disability Services, Bryant Student Union, Room 204F, Ocala Campus, 3001 S.W. College Road, Ocala, FL 34474-4415, fax to 352-873-5882 or email disability@cf.edu. Call 352-854-2322, ext. 1580, 1421 or 1209 for further information.