Palomar College
Disability Resource Center

1140 W. Mission Rd.
San Marcos, CA 92069
760-744-1150 Ext. 2375
Fax 760-761-3509

Instructions: Form is to be filled out by ***student (or former student)*** requesting information. Given the nature of services provided by this office, the ***student (or former student)*** may be contacted in order to verify information and explain limits of information shared. This form may be mailed or faxed to our office.

CONFIDENTIAL RELEASE OF INFORMATION

I hereby authorize the Palomar College Disability Resource Center (DRC) to release to:

_____
Name or Institution

_____
Address City State Zip Code

_____
Phone Number **and/or** Fax Number, Including Area Code

Information regarding services received **and/or** educational and medical records for the purpose of: ☐ **Disability Verification** ☐ **Other**(specify)_____

Student Name:_____ ID#:_____
(Please Print)

Address:_____

Phone:_____ E-mail:_____

This consent is valid until: ☐ **Until Revoked** **or** ☐ **Date:**_____

I understand that I may only revoke this form by notifying, in writing, the Palomar College Disability Resource Center. I further understand that, after the above specified date or revocation of this form, I will need to sign a new release form should I wish to continue to authorize the release of information.

_____ _____
(Student Signature) **(Date)**

PLEASE ALLOW 2-3 BUSINESS DAYS FOR YOUR INFORMATION / DOCUMENTS TO BE SENT TO THE RECIPIENT