MOUNT IDA COLLEGE

Consent to Receive and Release Information

Student Name_____ Birth Date_____

MIC ID # _____

I agree that any appropriate person and/or agency or institution can receive and release information consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies to this university for use in my educational and vocational planning. All information will be kept confidential and maintained as a part of my records with the Office of Accessibility Services (OAS) at the university. Selected information may be released for mandated State and/or Federal reports. I authorize the release of information which may include one or more of the following records:

____ Medical data verifying disability/medical condition and functional limitations and accommodation recommendations

_____ Psychological testing and evaluation results (DSM-V Classification)

_____ Nueropychological and Learning Disability assessment evaluations

_____ Section 504 and Department of Rehabilitation plans

____ Educational records, including progress made

___ Other:_____

I further give permission for OAS staff to discuss my educational situation with (initial as applicable):

_____ Medical Professional _____ Health Services _____ Other: _____

This authorization shall remain in effect until revocation in writing has been received by the Mount Ida College Office of Accessibility Services.

_____ _____

Signature of Student Date

_____ _____

Director of Accessibility Services Date

Return To:

Mount Ida Office of Accessibility Services

Accessibility@mountida.edu

jberon@mountida.edu

777 Dedham St. Hallden Center, RM 13

Newton, MA 02459

617-928-4648 Fax: 617-969-6909