



SIMMONS COLLEGE  
DISABILITY SERVICES  
Main Campus Building, Room E-108  
300 The Fenway, Boston, MA 02115  
p. 617.521.2474 f. 617.521.3079

## Authorization for Release of Confidential Information

SIMMONS ID#

\_\_\_\_\_

NAME \_\_\_\_\_

CELL PHONE ( \_\_\_\_\_ ) \_\_\_\_\_ EMAIL \_\_\_\_\_

I, \_\_\_\_\_, make the following authorizations regarding the release of information pertaining to my disability, documentation, and disability related needs for the purpose of assisting me in my academic program, as well as in determining reasonable accommodations at Simmons College.

**Parent, Family Member, Legal Guardian**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**Licensed Healthcare Professional**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

**OTHER – Please indicate below (i.e. release information to college/university)**

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

I understand that I may revoke this release at any time. By signing this release, I understand that the Disability Services Office will not contact these individuals, but may release information to those noted if applicable. This release will automatically expire one year from today's date.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_