THE KING'S COLLEGE

DISABILITY RELEASE AUTHORIZATION FORM

Christopher Josselyn, Academic Support Coordinator & ADA/504 Coordinator
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I, _____, hereby authorize the
(Student's Name)
following individuals and/or organizations to release all treatment records, relevant tests and case summaries in their possession regarding me to The King's College (TKC), and for TKC to discuss such information in its possession to the individual and/or organizations listed below:

Name of individual and/or organizations who will release or receive information:

_____

_____

_____

_____

Please complete a form for each physician or clinician whose documentation you have provided to the ADA/504 Coordinator.

This authorization allows the above individuals and/or organizations to copy and send records to TKC and allows representatives of TKC to review the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with TKC staff.

Student's Name: _____ Student ID:_____

Student Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____
(If student is under age 18)