**CHESTNUT HILL COLLEGE**

**CENTER FOR ACCESSIBILITY AND LEARNING SERVICES (CALS)**

**Release of Confidential Records**

**Student Record Release**

**Please print or type with blue or black ink. This document should be completed for EACH individual, school or agency whose records are relevant to a determination of your disability and reasonable accommodations. You may make as many copies of this form as needed. After you complete each of the Release Forms, give the original forms to 1) Director, Center for Accessibility and Learning Services and COPIES to 2) each individual or agency with whom you want to share information. It is your responsibility to mail copies of each form to the designated resource.**

Date:

Student’s Name: Date of Birth:

Maiden Name or Other Name Used:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: City: State: Zip Code

Social Security or ID Number:

E-mail Address:

I, (Student’s Name) hereby authorize the following individuals, agency or institution to release to and to communicate with the Chestnut Hill College Disability Resource Center the information and records identified below. **All non-medical/mental health records must be dated within five years prior to the date of this Release and/or normed for adults. Medical records and mental health records must include current diagnosis within the past 12 months.**

Name / Title / Agency:

Address:

City, State, Zip Code:

Telephone:

E-mail Address (if known): Fax Number (if known):

Information forwarded from the above professional/agency/institution/school will include those items specifically checked below (please check appropriately for each individual, agency, etc.):

 \_\_\_504 Service Agreements

 \_\_\_Audiology and/or Speech/Language Pathology Evaluation and Diagnosis

 \_\_\_Behavior Analyst Evaluation and Diagnosis

 \_\_\_Individualized Education Program Reports (IEP)

 \_\_\_Medical Evaluation and Diagnosis

 \_\_\_Mental Health Evaluation and Diagnosis

 \_\_\_Neurological Evaluation and Diagnosis

 \_\_\_Neuro-psychological Evaluation and Diagnosis

 \_\_\_Psychiatric Evaluation and Diagnosis including prescribed medications and dosages

 \_\_\_Psychological/Psycho-educational Evaluation and Diagnosis

 \_\_\_Other Records (please specify):

The above information will be used in determining whether I am eligible to receive reasonable Accommodations under the Americans with Disabilities Act of 1990 and its 2008 (ADAAA) amendments. This request is also consistent with the Federal Family Educational Rights and Privacy Act of 1974 (FERPA) and the Academic Policies for Students with Disabilities at Chestnut Hill College.

**Permission to Release/Exchange Information**

This consent will begin the date of this authorization and remain in effect during my enrollment at Chestnut Hill College or until revoked in writing. I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of this release. All information released will be handled confidentially and in compliance with federal and state regulations**. I further give permission for members of the Center for Accessibility and Learning Services at Chestnut Hill College to discuss my educational profile with other Chestnut Hill College professionals who have a legitimate educational interest\* in my academic, socio-emotional/behavioral and/or medical needs** or as may be needed in order to evaluate the existence of a disability and/or the accommodations necessary to address the disability.

\*Advisor, Student Health Center ,Counseling Center, orChestnut Hill College administrative personnel, instructors, and staff, Center Chairs and/or Program Coordinators.

I understand that all information released and discussed will be utilized for the benefit of my academic program at Chestnut Hill College and for the purpose of preparing/providing the reasonable accommodations, auxiliary aids, and services for which I may be eligible. I understand I may rescind or amend this *Release* at any time which, unless stipulated differently, will remain in effect while I am a student at Chestnut Hill College.

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Student’s Signature Date

**If you do not want information shared with your parent/guardian, initial here \_\_\_\_\_\_\_\_\_\_\_\_.**

This authorization will remain in effect during my enrollment at Chestnut Hill College. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Chestnut Hil Center for Accessibility and Learning Services address.

Signature of Student :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Authorization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Authorization:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Required for Student under 18 years of age.*

All information should be forwarded to:

Saundra M. Freedman, M.Ed.

Interim Director Center for Accessibility and Learning Services (CALS)

Chestnut Hill College

240 St. Joseph Hall

9601 Germantown Avenue

Philadelphia, PA 19118

freedmans@chc.edu

Phone: 215-242-7738

Fax: 215-242-7748

Date Received in CALS:

Revised: May 2, 2022