

ASHEVILLE-BUNCOMBE TECHNICAL COMMUNITY COLLEGE
340 VICTORIA ROAD
ASHEVILLE, NC 28801

_____/_____/_____
Name of Student or Applicant Date of Birth Social Security Number

CONSENT FOR THE RELEASE OF INFORMATION

Third Party: _____

FAX: _____ PHONE: _____

I consent to the release by Annie Clingenpeel of any information she has concerning the student to the above-named third party. This includes but is not limited to background data, diagnosis, academic performance, and educational planning data.

I also consent to the release to Annie Clingenpeel any information the above-named third party has concerning the client/student. This includes but is not limited to background data, findings, diagnosis, treatment, and educational records or planning data.

I understand that my records are protected under confidentiality legislation and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I understand I may revoke this consent at any time except to the extent that action has been taken. This authority expires with the completion of all transactions related to services provided by Asheville-Buncombe Technical Community College unless otherwise specified.

Signature of Student

Date

Signature of Parent, Guardian, or
Authorized Representative (when required)

Date

Witness

Date

Dear _____,

Thank you very much for your cooperation.

Annie Clingenpeel, M.S., LPC
Disability Services Coordinator/Counselor

Date