



**DISABILITY SERVICES OFFICE  
 MT. HOOD COMMUNITY COLLEGE  
 26000 S.E. Stark Street  
 Gresham, OR 97030  
 (503) 491-6923 FAX (503) 491-7549**

**REQUEST FOR RELEASE OF RECORDS OR INFORMATION**

Student's Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Date of Graduation: \_\_\_\_\_

I give permission and hereby authorize, \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

To release records and information to:

**Liz Johnson  
 Counselor and Coordinator of Disability Services**

Concerning the following areas:

- LD assessment with V.I.Q, P.I.Q, F.S.I.Q, and scaled subtest scores; in addition to achievement tests with standard scores
- Psychological/Psychiatric/Intake report verifying DSM-IV Diagnosis
- Medical diagnosis – physical
- Visual testing report with diagnosis
- Audiological testing report with diagnosis
- Recommendations for classroom accommodations
- Other \_\_\_\_\_

I understand that this information will not be re-released without my written consent, and kept confidential.

This authorization is valid for one year from the date of signature.

\_\_\_\_\_

Signature

\_\_\_\_\_

Date