ACADEMIC SUPPORT OFFICE

Consent to Release Information Agreement
I acknowledge that ASO advisors and/or the Director of ASO may share pertinent information, either that received or generated by Reinhardt University, with members of the Faculty/Staff or medical personnel where appropriate. The Academic Support Office (ASO) works collaboratively with faculty/staff or medical personnel on behalf of students in order to effect accommodations or assist a student with a disability related issue; however, this communication is on a need to know basis only.

I acknowledge that electronic mail (email) is not a secure medium. I give permission for ASO personnel to communicate with faculty/staff or medical personnel via email on an as needed basis. However, ASO will not include specific disability or diagnosis with a student’s name.

I am 18 years of age or older. **

_______________________________________________________________
Student Signature Date

_______________________________________________________________
CDS Coordinator Signature Date

**Student is under 18 years of age

_______________________________________________________________
Signature of Parent or Guardian Date

I am an active client or applying for services with the Department of Vocational Rehabilitation. I give ASO staff permission to communicate with my VR Counselor.

Name and contact info:

_______________________________________________________________

I give ASO staff permission to talk to my doctor or any other medical personnel that I work with on an as needed basis.

Name and contact info:

_______________________________________________________________
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Name and contact info:
_______________________________________________________________
_______________________________________________________________
_______________________________________________________________