

## 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. \*\*

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Student Signature Date

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CDS Coordinator Signature Date

\_\_ \*\*Student is under 18 years of age

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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:

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\_\_\_\_\_ 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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