

RECORDS RELEASE FORM

NAME: _____ TO: _____
Agency/Institution
SS# _____
Counselor or Physician

With my signature, I hereby grant permission for the release of my records to the Disability Services Representative at Gwinnett Technical College (address below), with the understanding these records will be kept at Gwinnett Technical College in accordance with all State and Federal regulations pertaining to student records.

The information I request released is in regard to:

_____ **DIAGNOSIS OF DISABILITY**

On professional/company letterhead, please address physical and/or mental impairment and pertinent information relating to potential and real barriers to academic performance. Please do not send complete medical file, but attach supportive testing and assessment such as audiogram, neurological, and visual measures, etc. that may be needed.

_____ **TESTING AND ASSESSMENT REPORT/PROFILE**

Aptitude/Achievement Neurological Career/vocational Memory/Cognitive

_____ **SUGGESTIONS FOR CLASSROOM ACCOMMODATIONS**

Examples: Extended time for assignments, use of tape recorder, guided notes, wheel chair access, assistive listening device, large screen monitor, and/or special testing arrangements, and/or any other academic support that you feel appropriate.

_____ **OTHER** _____

STUDENT SIGNATURE _____ DATE _____

Send requested information to:

Disability Services Office
Gwinnett Technical College
5150 Sugarloaf Parkway
Lawrenceville, GA 30043-5702
Phone: 678-226-6672
dgerardo@gwinnetttech.edu
FAX: 770-685-1266

THANK YOU

Gwinnett Technical College
(Revised 09/05/2007)