



Office of Student
Accessibility Services

FISHER COLLEGE

AUTHORIZATION FOR RELEASE OF INFORMATION

NAME _____ STUDENT ID _____

ADDRESS _____ PHONE _____

EMAIL _____ ACADEMIC PROGRAM _____

I, _____, give my permission for the Office of Student Accessibility Services (Print Name) to exchange information relevant to my development as a student at Fisher College with the following individuals, offices and/or agencies:

Please check all that apply:

___ Academic Affairs

___ Faculty Advisor

___ Admissions Office

___ Health Services

___ Co-Curricular Life

___ Parents/Guardians

___ College Counselor

___ Registrar's Office

___ Course Instructor

___ Residence Life

___ College Psychiatrist

___ Tutors/Academic Center for Enrichment

___ Outside Agencies:

___ Other

Please Specify _____

Name of Agency/Contact Person _____

Address/Phone _____

This release is valid: 1) during my enrollment at Fisher College ___ or 2) for the semester ___/_____.
Sem Yr

At any time, the student has the right to revoke this release of information. All information shall remain confidential.

Student Signature

Date