Permission for Release of Information

I give permission for the exchange of any medical, educational, or psychiatric information between the following departments of Wingate University:

- ☐ Disability Support Services
- ☐ Student Health Services
- ☐ Office of Counseling
- ☐ Residence Life
- ☐ Other_____

To becompleted by the student. (Please print)

Name of Diagnosing Professional:	
Title of Diagnosing Professional:	
Address:	
Phone:	Fax:

To becompleted by the student. (Please print)

Student's Full Name:	
Home Address:	Phone:
Email:	Student ID#:

To be signed by student if age 18 or over. To be signed by parent or guardian only if student is under age 18).

Signature:_____ Date:_____

Return to:
By Mail: Academic Resource Center, Wingate University, PO BOX 159, Wingate, NC 28174
By Fax: 704-233-8268
By Scan: access@wingate.edu (Please include the subject line: Housing Accommodation Request Student Last Name, Student First Name)