



Consent For Release of Information Form

Student's Name (Last, First): _____

W Number # (Chabot College Student ID number): _____

Phone Number: _____ Date of Birth: ____/____/____

Consent Expiration Date (write N/A if not applicable): ____/____/____

I hereby request and authorize DSPS Chabot College to release or exchange any disability, medical, and/or educational information they have concerning me to:

Name: _____

Relationship to student: _____

Phone Number: _____

Signature of Student:

Today's Date: ____/____/____

Signature of Counselor / DSPS Staff Witness:

Today's Date: ____/____/____