



CONSENT FOR RELEASE OF INFORMATION

Academic Success Center – Accessibility Services

Savitz Hall, Suite 237
201 Mullica Hill Road
Glassboro, NJ 08028
Phone: 856-256-4259

Student Information

Student Name: _____

Banner ID #: _____

Authorization for Release of Information

I, _____, hereby give my written consent for the Office of Disability Resources to release information considered pertinent (psychological, medical, and/or academic) to the following individuals or offices:

Office / Individual	Yes	No	Student Initials
My Professors at Rowan University	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan Tutoring Center	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan University Advising Center	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan Wellness Center	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan Counseling & Psychological Services	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan University Personnel (as needed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Individuals/Organizations with Official Rowan Partnerships	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rowan Global Learning & Partnerships	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other (please specify): _____	<input type="checkbox"/>	<input type="checkbox"/>	_____

Other (please specify): _____ _____

Parent/Guardian Authorization (If Applicable)

If you wish to authorize release of information to a parent or legal guardian, please complete the section below.

Name of Parent/Guardian Authorized to Receive Information:

Relationship to Student:

Phone Number:

Email Address:

- Yes, I authorize the release of pertinent information to the individual listed above.
- No, I do not authorize release to a parent/guardian.

Student Initials: _____

Note: Authorization applies only to the individual listed above. Any additional individuals must be specified separately.

Release and Acknowledgment

I further release all parties stated herein from any legal liability resulting from the release of this information, with the understanding that all parties involved will exercise appropriate safeguards while using this information.

I understand that the University will accommodate my educational and individual needs to the extent possible. However, I acknowledge that the University does not provide personal devices (such as wheelchairs), individually prescribed devices (such as hearing aids), or services of a personal nature including assistance with eating, toileting, dressing, or transportation for personal needs. If I require these services, I understand it is my responsibility to provide for my own assistance.

Student Signature: _____

Date: _____