CONSENT FOR RELEASE OF INFORMATION

Academic Success Center – Disability Resources
Savitz Hall, 304
201 Mullica Hill Road
Glassboro, NJ 08028
856-256-4259(P) 856-256-4438(F)

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:

- My professors at Rowan University
- My parent(s) or guardian
- Rowan Tutoring Center
- Rowan University Advising Center
- Rowan Wellness Center
- Rowan Counseling & Psychological Services
- Rowan University Personnel (as needed)
- Anyone who has an official partnership with Rowan
- Rowan Global Learning & Partnership
- Other (please specify):

  ___Yes   ___No   ___Initial

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 sufficient safeguards while using this information.

I am aware that the University will accommodate my educational and special individual needs to the extent possible. However, I am aware 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 in eating, toiletries, dressing, or transportation for personal needs. Should I require these services, I understand it is my responsibility to provide for my own assistance.

__________________________  ___________  ___________
Signature of Student        Banner ID #        Date