



CONSENT FOR RELEASE OF INFORMATION

Academic Success Center - Disability Resources
Savitz Hall, 304
201 Mullica Hill Road
Glassboro, NJ 08028
856-256-4233(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 | ___ Yes | ___ No | ___ Initials |
| My parent(s) or guardian | ___ Yes | ___ No | ___ Initials |
| Rowan Tutoring Center | ___ Yes | ___ No | ___ Initials |
| Rowan University Advising Center | ___ Yes | ___ No | ___ Initials |
| Rowan Wellness Center | ___ Yes | ___ No | ___ Initials |
| Rowan Counseling & Psychological Services | ___ Yes | ___ No | ___ Initials |
| Rowan University Personnel (as needed) | ___ Yes | ___ No | ___ Initials |
| Anyone who has an official partnership with Rowan | ___ Yes | ___ No | ___ Initials |
| Rowan Global Learning & Partnership | ___ Yes | ___ No | ___ Initials |
| Other (please specify): | ___ Yes | ___ No | ___ Initials |
| _____ | ___ Yes | ___ No | ___ Initials |

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