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	____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