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