COAHOMA COMMUNITY COLLEGE
Disability Support Services
3240 Friars Point Road Clarksdale, MS 38614 Ph: (662) 621-4853 Fax: (662) 624-6424

CONSENT FORM

Name: _____ Date: _____

ID #:_____ D.O.B.: _____

I hereby authorize Coahoma Community College's Office of Disability Support Services to communicate with the following: *(Please Check)*

____ Parents

List exclusions: _____

____ Coahoma Community College Faculty/Staff, On Campus Services (i.e. Health Clinic, Residence Life, etc.)

List exclusions: _____

____ Off Campus Services (i.e. Professionals, Schools, Vocational Rehab., etc.)

List exclusions: _____

Communication as denoted above may include obtaining and/or releasing student's historical and/or current information regarding assessment, diagnosis, needs, recommendations, treatment, prior services, academic records, performance, or information that may relate to accommodating student's needs on CCC's campus.

Signature: _____ Date:_____

Witnessed by: _____ Date:_____

This consent form will be valid until revoked by student. A photocopy of the original consent form shall be as valid as the original consent form.