Allan Hancock College
Learning Assistance Program
800 South College Drive, Santa Maria, CA 93454
(805) 922-6966, Ext. 3274
Fax: (805) 922-3556

CONSENT FOR RELEASE OF INFORMATION

Name: _____

DOB: _____

Social Security (last 4) _____

Maiden or other name used: _____

To: Doctor, School, Agency _____

Address/Location: _____

I, the undersigned, consent to, and request, all appropriate persons, agencies or institutions to release information regarding myself consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies to Allan Hancock College for use in my educational/vocational planning. All information will be kept confidential and maintained as a part of my records with the Learning Assistance Program Office at the college. I authorize the release of information to include any of the following records:

- ☐ Psychological Evaluation
- ☐ (DSM-5 diagnosis if available)
- ☐ Learning Disabilities Assessment
- ☐ (WAIS Raw Scores if available)
- ☐ Medical Records
- ☐ Audiology and Speech/Language Pathology Reports
- ☐ Vocational Rehabilitation Plan
- ☐ School Transcripts
- ☐ Vocational Evaluation
- ☐ Verification of Disability
- ☐ Other _____

I further give permission for the LAP certificated professional(s) to discuss my educational situation with other professionals who have a legitimate educational need to know. This authorization shall remain in effect during my enrollment or until revoked in writing.

_____ _____
Student Signature Date

_____ _____
LAP Specialist LAP Counselor

A PHOTOCOPY OF THIS FORM IS AS VALID AS THE ORIGINAL