Cleveland State
COMMUNITY COLLEGE
ACCESS Center
Student Center • RM 118
3535 Adkisson Drive • Cleveland, TN 37320
Phone: (423) 478-6217

Authorization for Release of Information

Student's Name: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

I, _____,
(Please Print)

authorize the release of all necessary records, including but not limited to testing, evaluations, and diagnostic materials to Disability Support Services at Cleveland State Community College for the purpose of documenting my disability. I further give my authorization for Disability Support Services to contact the provider (psychologist, physician, VR counselor, or other person/agency) listed on this authorization in the event additional information is required. Documentation must be dated and signed by a qualified professional and should include a clear and concise diagnosis, age of onset, functional limitations, current level of functioning, test instruments used, and history of treatment.

I understand that this authorization may be withdrawn by me at any time through a written, signed, and dated request. Disclosure of your social security number (SSN) is required of you in order for Cleveland State Community College to provide proper accommodations and services as mandated by applicable Federal and State law. Further disclosure of your SSN is governed by the Tennessee Public Records Act and other applicable law.

Signature: _____ Date: _____

Name of Provider: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email Address _____

Please return completed form to:

ACCESS Center/Disability Support Services
3535 Adkisson Drive
P.O. Box 3570
Cleveland, TN 37320-3570
Fax: (423) 614-8724 • Phone: (423) 473-2427
www.clevelandstatecc.edu