



HENDRIX COLLEGE

1600 Washington Avenue
Conway, Arkansas 72032-3080

Student Name	ID Number	Date of Birth
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The Hendrix College Office of Academic Success is hereby granted my permission to release to and/or obtain from:

Full Name of Person, Institution or Agency

Address	City	State	Zip Code
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Fax	Phone
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Information to be released: Disability Accommodations

I understand that the purpose for the disclosure of the above information is to aid in your treatment by the coordination of services.

I understand that the information released may be written (mailed), electronic (fax) or verbal. I further understand that this information will not be forwarded to anyone else by the recipient without my written consent. Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Date, event or condition which this consent is void.

Student's signature	Date
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Witness' signature and Title	Date
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