

**CONSENT TO RELEASE INFORMATION**

**TO: Honolulu Community College Student ACCESS**

**FAX No: (808) 844-2391**

I hereby request and authorize you to release the information and records designated as follows:

\_\_\_\_\_ Disability Documentation (medical diagnosis, physical limitations, psycho-educational assessment, and recommendations for accommodations in educational setting, if available):

\_\_\_\_\_ for documents on file at your office **or**

\_\_\_\_\_ for documents limited to the following condition(s):

\_\_\_\_\_ I give my permission to have you discuss my disability, educational (initial) program, and progress, and goals for purposes of planning and coordinating appropriate support services with \_\_\_\_\_ of

(Name)

\_\_\_\_\_  
(Agency)

\_\_\_\_\_  
(Phone Number)

**Please mail these disability documents directly to:**

**Student ACCESS  
874 Dillingham Blvd. Bldg. 7 Rm. 319  
Honolulu, HI 96817  
ATTN: Wayne Sunahara**

I understand that this consent will aid in the process of obtaining my health clearance(s) and/or disability documents required for registration or services. I have had an opportunity to ask questions and am satisfied with the reason and purpose for which my permission is given.

\_\_\_\_\_  
Last Name, First Name M.I. (Print)

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
School I.D. Number

\_\_\_\_\_  
Daytime Phone Number

\_\_\_\_\_  
Parent's/Guardian's Signature for Minors

\_\_\_\_\_  
Email Address

X \_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

SSD Office notes: Mailed successfully \_\_\_/\_\_\_/\_\_\_ at \_\_\_:\_\_\_ am/pm  
Other Notes: