

## CONFIDENTIALITY AND INFORMED CONSENT

Name: _____	Date of Birth: _____
Student ID #: _____	
Maiden Name or Other Used: _____	

Reports and other written information pertinent to the DSPTS student are kept confidential and maintained in the DSPTS office at Mesa College. Selected data may be released **with no** personal identification as data for mandatory state reports.

I, the undersigned, give permission for Disability Support Programs & Services (DSPTS) counselors to discuss my disability-related needs and educational situation with other professionals who have a legitimate educational need to know (consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or college policies).

- Consent to share information with faculty.
- Consent to share information with the Department of Rehabilitation and/or Regional Center.
- Consent to share information within the San Diego Community College District.
- Consent to share information with family members.
- Consent to share information with treating professional(s).
- Consent to share information with \_\_\_\_\_

This authorization shall remain in effect during my enrollment or until revoked in writing.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date