Consent to Share Disability Information

2411 NW Carden
Pendleton, OR 97801

(541)278-5759 Service Center
(541)278-5871 Service Center Fax
www.bluecc.edu

BMCC ID: _________ - ___________ OR SSN: ________ - _______- ________

Last Name: _________________________________ First Name: __________________________

Have you requested Directory Exemption? Yes ☐ No ☐ Date of Birth: _____/______/__________

I, ___________________________________, wish to have information regarding my disability shared between BMCC Disability Services staff and specific individuals for the purpose of assisting them in understanding any or all of the following: abilities and disabilities, request for accommodations, health and safety needs, strategies that are effective, and academic success.

I give my consent for this confidential information to be shared verbally or in writing between BMCC Disability Services and the following persons and/or agencies:

☐ BMCC Employees involved with my education and services

☐ High School Counselor (Provide Name and Contact Number) __________________________________

☐ Private Physician/Counselor, Therapist, Vocational Rehabilitation, (Provide Name and Contact Numbers) This is an open release to communicate:
____
____

☐ Family Member Name and Contact Number) ____

☐ Emergency Contact: If we know you have an emergency on campus, is there someone you wish BMCC Disability Services to notify? (Provide Name and Contact Information)
____

I understand that each person listed above will be informed that the confidentiality of this information is protected by state laws (ORS 192.500 and ORS 179.505) and federal law (PL 93-380, the Federal Family Education Rights and Privacy Act of 1974). The information shared with them is for their knowledge only and will not be shared with others unless I am informed or give my consent. Consent may be withdrawn by written notice.

Student Signature: _________________________________ Date: ______/______/______