# Consent to Share Information

**Student Health & Wellness Resource Center**
**Services for Students with Disabilities**

Phone 541-278-5965
Fax 541-278-5870
disabilityservices@bluecc.edu

www.bluecc.edu

BMCC ID: _____ - _____

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 & Contact Number) _____

☐Private Physician/Counselor, Therapist, Vocational Rehabilitation, other College or Institutions (provide Name & Contact Numbers). This is an open release to communicate: _____

_____

_____

☐Family Member (name & 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 & 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 (PL93-380, the Federal Family Education Rights & 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 Consent may be withdrawn by written notice.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: _____