Shasta College

# Partners in Access to College Education

for students with disabilities
Phone (530) 242-7790, Fax (530) 225-4876
Room 2006, 11555 Old Oregon Trail, Redding, CA 96003

## Records Request

The student named below has requested services/accommodations through the Partners in Access to College Education office. In order to assist this student, we must have the information checked below.

To: _____ Date: _____
Name of Business/Agency/School: _____
Address: _____ State: ____ Zip: _____
Phone: _____ Fax: _____

**Return to**: Shasta College
Partners in Access to College Education
11555 Old Oregon Trail, Redding, CA 96003
Phone: (530) 242-7790
Fax: (530) 225-4876

Name of Student: _____ *SSN: _____

Other Names Used: _____ Birth Date:_____

I authorize the release of information regarding my disability(ies) to Shasta College Partners in Access to College Education. All information will be kept confidential and maintained as a part of my records with the California Community College Partners in Access to College Education. I give permission for Partners in Access to College Education professional(s) to discuss my disability with other professionals who have a legitimate educational need to know. I authorize the release of information to include one or more of the following records identified below:

- ☐ Psychological Testing and Psychoeducational evaluation results, and/or medical reports
- ☐ Learning Disability assessment including WAIS or WJIV, **raw and standard scores**
- ☐ Intellectual disability assessment including Wechsler Scales, WJ Psycho-Educational Battery, Stanford-Binet Scales, or Standard Progressive Matrices **standard scores**.
- ☐ Audiology and speech/language pathology reports
- ☐ Dept. of Rehabilitation Individualized Plan for Employment
- ☐ School Transcripts
- ☐ Summary of Performance Report (SOP)
- ☐ Regional Center Eligibility Verification
- ☐ Other_____

_____

**A photocopy of this document is as valid as the original.**
**This authorization shall remain in effect for one year from date of signature below or until revoked in writing by the undersigned.**

Signature of Student: _____ Date:_____

Signature of Parent or Guardian: _____ Date:_____
(Required for student under 18 years of age.)

* The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Disability Service Programs for Students. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information my be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statues regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a,note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 e seq.