INDIANA TECH

Office of Student Success

# Informed Consent and Release of Information

I, _____, give my consent for
(student name)

_____
(name of counselor, physician, psychologist, or psychiatrist)

_____
(address, city, state, zip, phone number

to release information regarding my diagnosis to:

Jessica Black
Traditional Disability Coordinator
Indiana Tech
1600 E. Washington Blvd.
Fort Wayne, IN 46805
Fax: 260.422.1376
Phone: 800.937.2448, ext. 2338

For the purpose of developing an Access Plan so that I may receive accommodations for a disability.

Student Signature: _____

Date: _____

Student Date of Birth: _____

**For Clinician's Use:**
Please describe how the student's disability impacts the student academically and any recommendations for accommodations.