Disability Resource Center

Release of Information

I _____, Z Œ Ç }v• vš v µšZ}Œ]Ì G
Basin College Disability Resource Center to disclose information to:

Name W_____ z z z z z z z_____

Address:_____

City: _____ State: _____

Zip: _____Phone: _____

Fax: _____

Information to be shared (mark all that you would like sent) :

BC, Disability Resource Center

t GBC

_____

(Fill in expiration date)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written fortification to the GBC, Disability Resource Center, 1500 College Pa Elko, NV 89801 or fax to (775)7 ó ô- õ ï ñ understand that information used or disclosed pursuant to the authorization may not be re-disclosed to entities outside of GBC without my written consent.

Name of Student: _____

Address _____

City: _____ ST: _____Zip: _____

Phone: _____mail E-_____

Student Signature: _____Date: _____

Updated 1 î/ í í/ î ì