VIRGINIA WESTERN

OFFICE OF DISABILITY SERVICES

High School Release of Information

I, _____, _____, request or authorize
PRINTED NAME DATE OF BIRTH

_____, _____ send a
NAME OF HIGHSCHOOL GRADUATION DATE

copy of file/records to **Office of Disability Services at Virginia Western Community College.**

INFORMATION TO BE RELEASED/DISCLOSED:

✓ I.E.P. or 504 Plan ✓ Most recent psychological (**Most Helpful**) ✓ Disability Information

PLEASE SEND REQUESTED INFORMATION TO:

Mail: Virginia Western Community College
Office of Disability Services S207
3096 Colonial Ave. SW
Roanoke, VA 24015

Fax: (540) 857.7918

Attention: Hillary Holland, LPC

Please note: By signing this release form, any records obtained are the sole possession of Virginia Western Community College's Office of Disability Services. These records are held confidentially by our office and once received, will not be released to the student or other personnel.

Student Signature: Date:

COMMENTS: