



LARAMIE COUNTY COMMUNITY COLLEGE RELEASE OF INFORMATION

_____ Student ID Number _____
(print full legal name)

I hereby authorize Laramie County Community College to release all information for the 20__-20__ and 20__-20__ academic year(s) regarding Disability Support Services.

Name _____ Relationship _____

Name _____ Relationship _____

For account security, you must also specify an account authorization password. The above listed individual(s) must know this password as well as your name and ID number in order for LCCC to release any information to them. The password should be one word; the word "password" is not acceptable.

Password: _____

I authorize the release of this information for the purpose of Disability Support Services at Laramie County Community College.

I understand that this release of information may be revoked at any time by contacting the LCCC Disability Support Services and that this release covers only the terms indicated and must be re-submitted if LCCC is to disclose information past the time frame indicated on this form.

Signature _____

Date _____

Mail to: Laramie County Community College
Disability Support Services
1400 E. College Dr.
Cheyenne, WY 82007