WASHINGTON STATE Council of Presidents

COMMUNITY AND TECHNICAL COLLEGES Washington State Board

TRANSFER OF DOCUMENTATION FORM

Student Name:	Date of Birth:	Student ID [sending institution]:
Address:	City, State, Zip:	Phone:

Acknowledgement

The Family Educational Rights and Privacy Act (FERPA) of 1974 (20 U.S.C. § 1232g; 34CFR Part 99) is a federal law that protects the privacy of student education records. This includes your records maintained for the purposes of providing disability resources for students. The release or disclosure of your records or any personally identifiable information from your records can only be disclosed in accordance with state and federal laws and the college or university policies regarding student records.

This transfer of documentation form provides your written consent to authorize the college or university to disclosure and release your records to persons to whom the college or university may not otherwise be authorized to disclose or release your records without your consent. You are under no obligation to sign this form.

Release of Information

I voluntarily give my consent to the sending institution listed below to release my education records and information in the possession of its disability resource office for the purposes of the receiving institution's disability resource office to evaluate my request for accommodations and/or to provide reasonable accommodation related to my disability.

This release includes the following information:

___ Documentation related to my diagnosis ___ Accommodation plan

Authorized Institutions

This release of information applies to education records held by the following institutions maintained for the purposes outlined above.

Sending institution:	Receiving institution:

Revocation

I understand that this release shall remain in effect for 90 days and may be revoked by me at any time. Revocation must be in writing, and my revocation is delivered to the college or university disability resource office. The revocation will not apply to disclosures made prior to the disability resource offices receipt of the written revocation.

By signing below, I acknowledge that I have read this form and I voluntarily give my consent for college or university to release my education records in accordance with the terms outlined above release of information.

Student Signature Date

I certify that I know or have satisfactory evidence that __________________ (student) is the person who signed this acknowledgment of rights and release of education records for the uses and purposes mentioned in the instrument.

Access Service Staff Signature Date

Name: Title:

College or Institution: Phone number: