Disability Services Office, SC229 | 2740 West Mason St, Green Bay, WI 54303 | 920-498-6904 | Fax: 920-491-3792
disability.services@nwtc.edu

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☐ NWTC Counseling Staff: ______________________________
(Verbal exchange of information only)

☐ NWTC Dean/Associate Dean ______________________________

☐ NWTC Advisors: ______________________________

☐ Other: ______________________________

Name of Person and Agency to be contacted ______________________________

Relative to my past or present involvement with the above named agency or person.

The purpose of this exchange is to facilitate the implementation of accommodations during the semester you are taking classes.

I understand that this authorization is revocable except to the extent that action has been taken in reliance thereon and that this authorization will remain in force until I am no longer receiving accommodations from NWTC Disability Services in order to effectuate the purpose for had the chance to talk about my questions and concerns,

which were answered to my satisfaction. I understand and agree with the above and I have received a copy of this release form.

______________________________ ______________________________
Student Signature Date

______________________________ ______________________________
Witness Signature Date

NOTE TO CLIENT AND RECIPIENT OF INFORMATION: This information has been disclosed to the above named person/organization from records whose confidentiality is protected by WI Statute 51.30, HFS 75.13 and/or Federal Regulation 42 CFR, Part II. These laws prohibit you from making any further disclosure of this information without the specific written consent of the person whom it pertains or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose.