RECORDS RELEASE FORM

TO: _____

Contact Person

_____

Agency Name

_____

Street Name and Number

_____

City, State and Zip Code

RE: _____

Student/Applicant's Name

_____

Student/Applicant's Date of Birth | Social Security Number (last 4 digits)

I hereby request and authorize you to release to Coastline Community College any medical, psychological, social, vocational, and/or educational testing information you have or may have for me. I am assured by the college that such information will remain confidential and be used on my behalf towards the effectiveness of my individual program. Please send any billing charges to me at the following address:

_____

Student/Applicant's Name

_____

Address | City, State, Zip Code

_____

Date | Applicant's Signature

_____

Date | Signature of Parent or Guardian*

**Required if student is under 18 years of age or is a legal ward of parent or guardian*

PLEASE MAIL/SCAN OR FAX RECORDS TO:

Special Programs and Services for the Disabled
Coastline Community College
1515 Monrovia Avenue
Newport Beach, CA 92663
Phone: 714-241-6214; Fax: 714-431-3602
specialprograms@coastline.edu