Authorization for Release of Confidential Information
Office of Disability Support Services
Gulf Coast State College
5230 W. Highway 98
Panama City, FL 32401

Name _____
First Middle Maiden Last

Address: _____
Number and Street or P.O. Box

_____
City State Zip

Birth Date: _____ Student ID Number: _____

I Authorize: (Name of doctor, physician, facility of treatment, school, college, etc.)

Name: _____

_____

Address: _____

_____

To release the following medical, social, psychiatric, psychological, and/or financial information pertaining to me:

_____

_____

_____

_____ _____
Student Signature *Date*

_____ _____
Witness Signature (If needed) *Date*

SEND INFORMATION TO:

LINDA VAN DALEN, COORDINATOR
DISABILITY SUPPORT SERVICES
GULF COAST STATE COLLEGE
5230 WEST U.S. HWY 98
PANAMA CITY, FL 32401
850-872-3834 FAX: 850-767-8037