

AEC Consent for Release of Information

Student Name *(Please Print)*

Student ID#

Select duration of release request:

- One time only.
- Valid for one year from signature date.

Release the following information, check all that apply:

| | |
|---|---|
| <input type="checkbox"/> Prescribed Accommodations | <input type="checkbox"/> Disability Documentation on-file with AEC |
| <input type="checkbox"/> Discussion <input type="checkbox"/> Document Release | <input type="checkbox"/> Discussion <input type="checkbox"/> Document Release |

Check one *(incomplete forms will not be processed)*:

- Student will pick up documentation in AEC Main Office.**
- AEC will send copy of requested documentation, release information to:**

Mail or Email

Name: _____
(Person or Organization)

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

By signing this form, I am hereby authorizing AEC professional staff members to release the above selected information.

Signature: _____ Date: _____

REQUESTS MAY TAKE UP TO 10 BUSINESS DAYS TO BE PROCESSED