



**Student Services**

**General Consent**

I, \_\_\_\_\_, give my permission for the Disability Services counselor to share my information concerning my disability with appropriate personnel at Lawson State Community College. I understand this information is confidential and will only be shared for academic and support services purposes on a need-to-know basis.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Disability Services Counselor

\_\_\_\_\_  
Date