3945 Forbes Avenue, #470
Pittsburgh, PA 15213
Phone: (412) 848-9355
Email: carolyn@aheadd.org

CONSENT FOR COMMUNICATION

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As a participating student in AHEADD, I agree to allow agents of AHEADD to communicate directly with my professors and related professionals as specifically identified below. **In addition to those persons listed below, agents of AHEADD also have my permission to speak with staff of Disabilities Resource Services and the administration of my school of study.** Communication may take the form of telephone conversation, email or meetings. I have the right to revoke my consent at any time.

_____	_____
Name of Professor / Related Professional	Email address / phone
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Name of Professor / Related Professional	Email address / phone

_____	_____
Signature of Student	Date
_____	_____
Signature of Witness	Date