Office for Students with Disabilities
Request for Services
& Academic Accommodations, Part II

Part II: Authorization to Share Information, for Student to Complete & Return to <OSWD@Gallaudet.edu>

I hereby authorize the Office for Students with Disabilities (OSWD) at Gallaudet University to obtain information from and/or release information to: *(Please check all that apply)*

☐	Student's Medical Personnel		☑	Gallaudet Faculty/Staff
☐	Counseling & Psychology Services (CAPS)		☐	Gallaudet Residence Life
☐	Vocational Rehabilitation Counselor		☐	Student Health Services
☐	Career Center			

	Other (specify →)	Name	
	(e.g., Parents)	Address	
		Phone/Fax	
		e-mail	

The purpose of this release is to help ensure I receive reasonable accommodations as listed in my medical and/or diagnostic records in compliance with the Americans with Disabilities Act of 1990 and subsequent amendments, and the Rehabilitation Act of 1973.

I understand that this Confidential Release of Information shall remain in force until such time as I withdraw it in writing, or I cease to be enrolled in the University.

Student Name		Student ID Number
Student Signature		Date