Authorization for Release of Medical Information

Please provide a signed copy of this release of information form to your current medical or mental healthcare provider when you ask them to write a letter or complete forms regarding verifying your need for disability accommodations in the academic setting.

I, _____(student name and DOB),

_____ **(initial)** request and authorize the following professional(s) listed below to release pertinent medical, psychological, educational, or vocational documentation and information regarding my disability for the purpose of postsecondary education planning and disability accommodation implementation to the Director of Accessibility Services at Brenau University;

_____ **(initial)** also authorize the professional/s listed below to speak with the Director of Accessibility Services at Brenau University about my medical, psychological, educational, and/or vocational history, treatment, diagnosis, opinions, and other related information regarding my disability for the purpose of postsecondary education planning and disability accommodation.

_____

Name of Licensed Professional

_____

Address

_____

City, State, zip code

_____

Phone# Fax#

I understand this authorization is voluntary and I may revoke this consent at any time through a written, signed, and dated request to the Director of Accessibility Services. The revocation will not apply to action taken prior to that date.

Student Signature_____ **Date** _____

Brenau University Office of Accessibility Services
Confidential Email: accommodations@brenau.edu
Fax: 770-297-5883