Disability Services for Students
1300 Elmwood Avenue SW 120
Buffalo, New York 14222
Phone: 716-878-4500
Fax: 716-878-3804

Authorization for the Release of Information

Full Name: ____

Date of Birth: ____

Student I.D. Number/SSN: _______________________________

This document hereby authorizes the following treating and/or educational source to release information to this office:

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Phone# (   ) ______________________ Fax# (   ) ______________________

The information requested includes the following types of reports:

- ☐ Academic progress reports
- ☐ Medical and/or mental health diagnosis and impact of disability
- ☐ Educational testing used to evaluate learning disabilities and other impairments
- ☐ Vocational assessments
- ☐ Audiograms
- ☐ Any further relevant documentation

Your opinion as to the limitations the student experiences and suggestions for services will assist this office in arranging the appropriate and necessary accommodations for the student. Strict confidentiality of these records will be maintained at all times. We greatly appreciate your assistance.

This consent is subject to revocation at any time, except to the extent that that the Office of Disability Services has already taken action in reliance on it prior to said revocation. If not previously revoked, this consent will terminate six (6) months after the date of my signature as it appears below.

Signed: ______________________ Dated: __________ Witnessed by: ______________________