

## **Authorization for Information Release Form C**

I, \_\_\_\_\_, authorize my current treating physician, psychiatrist, and/or other relevant individuals as listed below, to discuss with the Office of Services for Students with Disabilities the nature of my condition/disability, including medical records and history of treatment. The purpose of this release is to assist me in my College program, as well as in determining reasonable accommodations. I understand that this authorization may be withdrawn by me at any time through a written, signed and dated request.

Please indicate names of provider(s) below:

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Student Signature/Date