

Authorization for Information Release Form A

I, _____, authorize the Office of Services for Students with Disabilities to discuss any medical or psychological information pertaining to me with authorized members of Siena College administration and/or faculty for the purpose of assisting me in my 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 I understand that this authorization may be withdrawn by me at any time through a written, signed, and dated request.

Student Signature/Date

If any exceptions apply to this authorization, please list them below and initial: