SIENA
OFFICE OF ACCESSIBILITY

Authorization for Information Release

_____
Student Name (Please Print)

Initial Below

_____ I authorize the Office of Accessibility to discuss any medical or psychological information pertaining to me with authorized members of Siena University administration and/or faculty for the purpose of assisting me in my program and in determining reasonable accommodations.

_____ I authorize the Office of Accessibility to discuss with my parents or legal guardians any relevant academic or personal information for the purpose of assisting me in my program and in determining reasonable accommodations.

_____ I authorize my current treating physician, psychiatrist, and/or other relevant individuals, to discuss with the Office of Accessibility the nature of my condition/disability, including medical records and history of treatment for the purpose of assisting me in my program and 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I understand that this authorization may be withdrawn by me at any time through a written, signed, and dated request.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