Office for Students with Disabilities
Authorization to Release or Obtain Information

I hereby authorize the Office for Students with Disabilities (OSWD) at Gallaudet University to obtain information from and/or release information to: *(Please check all that apply)*

Academic Advising Staff
Admissions/Registrar's Office
Audiology Department
Career Center
Counseling & Psychology Services (CAPS)
Gallaudet Faculty/Staff*
Learning Disability Diagnostician
Medical Personnel
Residence Life
Student Health Services
Tutorial & Instructional Program
Vocational Rehabilitation Counselor

Other (specify →) Name ______________________________

Address ______________________________

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Phone/Fax ______________________________

e-mail ______________________________

The purpose of this release is to help ensure I receive reasonable accommodations as listed in my medical and/or diagnostic records in compliance with the Americans with Disabilities Act of 1990 and subsequent amendments, and the Rehabilitation Act of 1973. I understand that consent will expire in one year from my date of signature, or with my written notification.

Checking "Gallaudet* ***Faculty/Staff* *" authorizes OSWD to send Faculty Accommodation Letters (FALs) on my behalf to faculty in whose courses I enroll, for the period of consent.*

______________________________ ______________________________
Student Name Student ID Number

______________________________ ______________________________
Student Signature Date

____
Staff Name

______________________________ ______________________________
Staff Signature Date

I.K. Jordan Student Academic Center, 800 Florida Avenue, N.E., Washington, DC 20002-3695
202-651-5256 (voice), 202-250-2059 (VP), 202-651-5887 (fax), http://oswd.gallaudet.edu