



SUFFOLK UNIVERSITY

OFFICE OF DISABILITY SERVICES

Authorization for Request and/or Release of Information Form

I _____ authorize _____,
(Name of Student) (Name of Administrator)

the director of the Office of Disability Services, to release my records of disability to the person(s) listed below:

Name and Title: _____

Address: _____

City, State, Zip Code: _____

Fax number: _____

I request that the following information be released:
("contents of the file" is all that is required if you prefer not to state specific information)

I am requesting that my personal information be released for the following reasons:
("at the request of the individual" is all that is required if you prefer not to state a specific purpose)

I have a right to revoke this authorization, in writing, at any time by sending such written notification to the Office of Disability Services. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your personal information and no longer protected by the Family Educational Rights and Privacy Act (FERPA).

(Student name - PLEASE PRINT)

(Suffolk ID#)

(Signature of student)

(Date)
