



SUFFOLK UNIVERSITY

OFFICE OF DISABILITY SERVICES

Disclosure of Disability Agreement Form

I _____ authorize the Office of Disability Services (ODS) to share my disability diagnosis and any academic learning strategies, specific to my disability, with the following academic support centers:

- ___ Ballotti Learning Center
- ___ Math and Computer Science Support Center
- ___ Writing Center
- ___ Second Language Services
- ___ Athletics Department
- ___ The Office of Student Affairs
- ___ Retention Services
- ___ Counseling Services

I am authorizing ODS to only do this if the academic support center is seeking assistance in providing me with the best educational consultation available. I understand that this information will be shared with respect and dignity and will remain confidential between ODS and the academic support center. If I choose to terminate this agreement, I can do so at any time. If I have any questions I understand that I can contact ODS at: 617-994-6820 or via email at disabilityservices@suffolk.edu.

Signatures:

Student's: _____

Date: _____