S V A  School of Visual Arts

Authorization for Release of Information

I, _____, ID _____,
(Student Name) (Student ID#)

hereby authorize the following individuals and/or organizations to release all medical, psychological and educational evaluations or assessments in their possession to the Office of Disability Services (ODS) at the School of Visual Arts, and for ODS to discuss such information in its possession to the individual and/or organizations listed below:

Name of individual and/or organizations who will release or receive information:

_____

_____

_____

This authorization allows the above individuals and/or organizations to copy and send records to ODS and allows representatives of ODS to review the records. This authorization allows the above individuals and/or organizations to discuss my condition and needs with the ODS staff.

This authorization encompasses all records pertaining to my condition, including "third party records" created by any other individuals or organizations.

The following are specified as part of this authorization:

A. The purpose of disclosure is to assist the School of Visual Arts in determining whether I am eligible to receive reasonable accommodations for my disability in accordance with the Americans with Disabilities Amendments Act of 2008, and what accommodations may be appropriate.

B. I understand that I have the right to revoke this authorization at any time by providing written notification to School of Visual Arts or the individuals and organizations listed above, and that revoking this authorization does not apply to information that has already been released by this authorization.

C. I am also aware that any information disclosed to the School of Visual Arts is subject to other state and federal privacy laws, including FERPA, which protects student's records.

Student Signature: _____Date: _____