Office of Disability Services

CONSENT

FOR INTERNAL EXCHANGE OF INFORMATION

I, _____ (print name), understand that communications and records relating to my identity, diagnosis, prognosis, or consultation with the Office of Disability Services (FIT-ABLE) are confidential.

I authorize FIT-ABLE to exchange information and/or records regarding my identity, diagnosis, prognosis, or consultation only as necessary with the following staff members: (please circle all that apply)

1. The Counseling Center
2. The Health Services
3. The Dean for Student Development
4. Office of Residential Life
5. Office of Financial Aid
6. Other (please list):

_____

I understand that a refusal to grant consent to these disclosures will not jeopardize any right to obtain present or future services from the Office of Disability Services (FIT-ABLE). I also understand that I may withdraw my consent to this disclosure at any time by sending written notice of revocation to FIT-ABLE in A570.

_____ _____

Date Signature