



Disability Services for Students
 275 Eastland Road
 Berea, Ohio 44017
www.bw.edu/DisabilityServices
 Phone: (440) 826-2147
 Fax: (440) 826-3832
 Email: disability@bw.edu

Release and Exchange of Information Authorization Form

STUDENT INFORMATION (Please Print)

Name (Last, First, Middle): _____

Date of Birth: _____ BW ID Number: _____

Status (check one): current student transfer student prospective student

Phone: (_____) _____ - _____ BW Email: _____ @bw.edu

Address (street, city, state, zip code): _____

I authorize Disability Services for Students (DSS) to:

Release Information to Obtain Information from

Provider Name (Print): _____

Title: _____

Mailing Address: _____

Phone: (_____) _____ - _____ Fax: (_____) _____ - _____

Unless otherwise revoked, this authorization shall remain in effect until _____.

If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed. This authorization may be revoked at any time. The revocation must be in writing, signed by me or my representative, and delivered to Disability Services for Students (DSS). The revocation will take effect when DSS receives it, except to the extent that DSS or others have already taken action on this authorization.

By signing below, the student grants DSS permission to contact the provider for additional information.

I, _____ (printed name of student), hereby authorize DSS to obtain and/or release information from/to the provider indicated below in order to evaluate eligibility for academic accommodations.

Student Signature: _____ Date: _____

Witness Signature: _____ Date: _____

By selecting this box, I verify that the information provided is correct, that I am currently treated or have been treated by the provider, and that **I am not a relative of the provider.**