

Western Carolina University  
OFFICE OF DISABILITY SERVICES

**CONSENT FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_, give my permission for Dr. Lance Alexis, Director of the Office of Disability Services to receive medical and/or psychological information related to my disability from my physician, health care provider, or other individual or agency in order to be eligible to receive accommodations or related disability services at Western Carolina University.

I also give my permission for Dr. Lance Alexis to share information about my disability/medical condition or academic or access needs with my instructors and other campus officials on a need-to-know basis.

I understand that my disability documentation will be housed in the Office of Disability Services office in a confidential manner, and that I have the right to review my records. I have been informed that I have the right to limit or withhold information related to my disability from any individual and that I may cancel this authorization at any time.

Additional Comments (if you wish to make any): \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature (*typing your name suffices*)

\_\_\_\_\_  
Date

Last four digits of SS#: \_\_\_\_\_

Student ID #: \_\_\_\_\_