THE OHIO STATE UNIVERSITY

Office of Student Life

Disability Services

098 Baker Hall
113 W. 12th Ave.
Columbus, OH 43210-1301

614-292-3307 Phone
614-292-4190 Fax
614-500-4445 VP

slds.osu.edu

Authorized Release Form

Name.#
Address

BuckID #
Phone #
DOB

With this form I permit Student Life Disability services to:

☐ Release information to the designated parties below

☐ Receive information from the designated parties below

Name/Agency	Phone #

The information I am permitting to be shared is about my:

☐ Accommodations and registration status

☐ Disability status and diagnosis/es

☐ Documentation and treatment plans

☐ Other (please specify):

Are there any additional notes, exceptions, or considerations when sharing your information?

If desired, please specify below the date range you would like this release to be valid. Otherwise, it will expire one year after the completion of services with Disability Services. You may cancel your permission at any time by informing Disability Services.

Effective: Expiration:

Signed: Date: