LINCOLN UNIVERSITY

PURPOSE OF DISCLOSURE

To facilitate the provision of reasonable academic, housing, and campus accessibility accommodations and support services through the Office of Access and Abilities, in accordance with the Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and the Fair Housing Act (FHA), as applicable.

STUDENT INFORMATION

STUDENT NAME: _____

DATE OF BIRTH: _____

PHONE NUMBER: _____

STUDENT ID: _____

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STUDENT INFORMATION

NAME OF PROVIDER/AGENCY AUTHORIZED TO RELEASE INFORMATION: _____

_____

TITLE/ORGANIZATION: _____

ADDRESS: _____

_____

PHONE : _____

EMAIL: _____

INFORMATION TO BE RELEASED

The information that may be shared includes, but is not limited to, documentation that supports the need for reasonable academic and/or housing accommodation(s) due to a physical, psychological, or learning disability or other relevant medical condition. This may include:

- Psychoeducational evaluations
- Medical/clinical assessments
- Diagnostic reports
- Neuropsychological test results
- IEPs or 504 Plans (current or past)
- Documentation of prior accommodations (e.g., in high school or another university)
- Summary of functional limitations

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TREATMENT SUMMARIES OR PHYSICIAN'S NOTES

OTHER RELEVANT DOCUMENTATION:

_____

_____

This authorization is valid until (check one):

☐ **ONE-TIME RELEASE**

☐ **UNTIL REVOKED IN WRITING BY THE STUDENT**

☐ **UNTIL THE END OF THE CURRENT ACADEMIC YEAR**
(_____)

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DELIVERY METHOD

INFORMATION MAY BE SENT VIA:

☐ **MAIL** ACCESS&ABILITYSERVICES@LINCOLNU.EDU

☐ **EMAIL** 822 Lee Drive Jefferson City MO 65101

INFORMATION TO BE RELEASED

I understand that I am not required to sign this form and that services are not contingent upon this release. I authorize the release of my records as described above.

I understand that I may revoke this consent at any time by submitting a written request to the Office of Access and Abilities. Revocation will not affect disclosures made prior to the receipt of the revocation.

[ ] I authorize verbal communication between the Office of Access and Abilities and the provider listed above.

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SIGNATURES

STUDENT SIGNATURE: _____

DATE: _____

WITNESS NAME/SIGNATURE:

_____

DATE: _____