



AUTHORIZATION FOR RELEASE OF INFORMATION

I, (print student name) _____ **ID#:** _____

Address: _____

City, State, Zip Code: _____

do hereby authorize, (Name/contact information of the certified diagnostician or doctor)

Name of individual or institution: _____

Address: _____

City, State, Zip Code: _____

to release the following information to:

**Morehouse School of Medicine
Office of Disability Services
720 Westview Drive, Harris Building, Room 132
Atlanta, GA 30310
Phone: (404) 756-5200 Fax: (404) 752-1639**

The following information (please check all that apply):

____ Medical Reports ____ Medical History ____ Social History

____ Teacher Progress Reports ____ School Transcripts ____ I.E.P.'s/Transition Plan

____ Psychological Evaluation ____ Other: _____

I understand that I have the right to inspect and to copy any or all of the above information, which is to be used to determine appropriate educational and/or supportive services.

This authorization is limited to the information specified above. I understand that I have the right to revoke this authorization at any time by submitting a written request and that my refusal to consent to the release of these records will prevent disclosure to the individual or institution named above. I also understand that certain refusals to authorize disclosure may result in MSM having insufficient information to assess my academic adjustment requests and, in some instances, may impact its ability to award an academic adjustment.

Signature: _____ **Date:** _____

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