



# Disability Services Office

Student (Print Full Name): \_\_\_\_\_

Student I-Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ DOB: \_\_\_\_\_

I agree to the exchange of confidential information regarding my disability between the Disability Services Office and:

\_\_\_\_ Parent(s)

\_\_\_\_ Doctor(s)

\_\_\_\_ Counselor

\_\_\_\_ Housing Manager/Owner

\_\_\_\_ Instructor(s)

\_\_\_\_ Other: \_\_\_\_\_

<b>Optional Contact Information:</b>	Name: _____
	Address or Email: _____
	Phone: _____
	Fax: _____

*(Do Not Fill Out This Section- unless you want us to send your documents somewhere else if needed.)*

The information exchanged should include the psychological/medical report, diagnosis, testing records, level of severity, and recommendations for academic accommodations. The information gathered will be used to determine appropriate accommodations while enrolled as a student at BYU-Idaho.

This release is valid from \_\_\_\_\_

Today's Date (mm/dd/yyyy)

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Witness Signature