STUDENT OF DISABILITY SERVICES
RELEASE OF INFORMATION

Name: ________________________________ Date of Birth: _________________________

Student ID: ____________________________ Phone Number: ________________________

_________ I understand that the Office of Student Disability Services has the right to share information, on an as needed basis, with my instructors and other personnel at MBU.
Initials

I AUTHORIZE THE OFFICE OF STUDENT DISABILITY SERVICES OF MISSOURI BAPTIST UNIVERSITY TO:
________ Create *VISA* in order to obtain accommodations in my classes. *Initials*

I AUTHORIZE THE OFFICE OF STUDENT DISABILITY SERVICES OF MISSOUR BAPTIST UNIVERSITY TO DISCUSS MY ACCOMMODATION NEEDS AND/OR ACADEMIC PROGESS AS THEY RELATE TO COLLEGE PROGRAMS WITH THE FOLLOWING:

_______ MBU Faculty and Staff
Initials ________________________________

_______ Family Members
Initials Name:__________________________
Relationship:__________________

_______ Vocational Rehabilitation Counselor
Initials ________________________________

_______ Rehabilitation Services for the Blind Counselor
Initials ________________________________

_______ St. Louis Regional Center
Initials ________________________________

_______ Veterans Administration
Initials ________________________________

_______ Other
Initials ________________________________

I understand that all information will be held in strict confidence.
I understand that I am entitled to a copy of this authorization.
This *Release of Information Form* will remain in effect every semester I am enrolled at Missouri Baptist University. I understand that I may revoke this release in writing at any time.

Signature of Student: ____ Date: ____________________

Signature of Witness: ____ Date: ____________________