Office of Disability Services

RELEASE OF INFORMATION

Information that you share with the Office of Disability Services regarding the nature of your disability is considered confidential. Such information will be maintained in ODS in a manner consistent with state and federal laws governing confidentiality. There will be times when legal counsel and other UIS administrators may need to have access to information about your disability to assist you and/or the University with a particular situation or legal matter. There will also be occasions when, in order to facilitate provision of accommodations, Office of Disability Services staff must talk with faculty or staff about your particular needs AND if needed share information about your disability.

_____ _____

Name Signature

_____

Date

The following statement addresses the right of the student's individual privacy. In the even a parent, step-parent, or guardian inquires about or calls on behalf of a student, the Office of Disability Services must have a written release signed by the student to be able to speak with them.

I give the Office of Disability Services permission to speak with my parents, step-parents, or guardians about me and my progress as a student registered in the Office of Disability Services at UIS.

_____ Agree _____ Disagree

_____ _____

Signature Date

With approval from ODS the University Registrar can provide students who are registered with Disability Services priority registration during the early enrollment period each semester. In order to insure that priority registration is available, your name must be released to them.

If you agree to have your name released to University Registration identifying you as a student registered with Disability Services, please indicate below.

_____ Agree _____ Disagree

_____ _____

Signature Date

As a student actively registered in the Office of Disability Services at the University of Illinois Springfield, (UIS) I, _____give my physicians, evaluators or any other individual who is involved in my medical care and evaluation of my medical/psychological disorder, permission to receive or to give to any staff member in the Office of Disability Services at UIS any information that will assist in my success at UIS.

_____ _____

Signature Date

University of Illinois at Springfield, Disability Services ~ One University Plaza, MS HRB-80, Springfield, IL 62703
217.206.6666 (Phone) ~ 217.206.6668 (tty) ~ 217.206.7154 (Fax)