SARAH • LAWRENCE • COLLEGE

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____ hereby authorize _____
print name clinician name
to provide the Office of the Dean of Studies at Sarah Lawrence College documentation of my disability. I understand that this information is confidential and will be used only for the purpose of enabling the College to provide me with supportive academic and other services related to my disability. I understand that the Dean's office or the Director of Health Services may contact the person providing certification for additional information.

SIGNATURE: _____

GUARDIAN SIGNATURE _____
(if student is under 18)

DATE: _____

Submit information to:

Beverly A. Fox
Associate Dean of Studies
Sarah Lawrence College
One Mead Way
Bronxville, NY 10708