Wellesley College Accessibility and Disability Resources
Release of Information Form

This form documents your request that information about your needs/disability be shared between Wellesley College Accessibility and Disability Resources and others you have specified.

Name: _____

Address: _____ Phone: _____

ID Number: _____ Email: _____

Permission to Release Information from Wellesley College Accessibility and Disability Resources to Individual Below

_____ I authorize Wellesley College Accessibility and Disability Services to release my Disability Information checked here with the individual or office listed below.

_____ My needs without specifying my disability(s)

_____ My needs AND specifying my disability(s)

_____ My medical/mental health documentation

Permission to Release Information from Individual Below to Wellesley College Accessibility and Disability Resources

_____ I authorize the individual or office listed below to share my medical/disability information with Wellesley College Accessibility and Disability Resources

Individual or Office with Whom Information is to be shared with WC Accessibility and Disability Resources

Name: _____
(e.g. WC faculty, staff, Health Service; Accessibility and Disability Resources office of another institution; Health Care Provider or Clinician)

Phone: _____

Address: _____ Fax: _____

_____ Email: _____

Signature: _____ Date: _____

This request will be valid for 6 months from date signed.

Wellesley College Accessibility and Disability Resources
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781.283.1300 accessibility@wellesley.edu