Office of Disability Services
Room 129 – Main Building
3250 Central Parkway
Cincinnati, OH 45223

Release of Information from ODS

I, ____________________________________, give the Office of Disability Services
(Printed Name)

permission to release my disability documentation / accommodation record / conversational information / medical information. I further give the person(s) listed below permission to participate and/or attend meetings relating to accommodations received for my disability at Cincinnati State.

This permission is granted to the following:

Name(s):____

Title(s)/Relationship:____

Institution:____

Address:____

Fax/Phone:____

For the purpose of: ____

____

_____________________________ _____________________________ ______________

Student Signature *Student ID#* *Date*