



Office of Disability Services
Room 169 – 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