



**Office of Disabilities Services**  
448 Institute Hill  
2<sup>nd</sup> Floor; VMI Health Center  
Lexington, Virginia 24450

## **AUTHORIZATION FOR EXCHANGE OF INFORMATION**

The purpose of this form is to authorize the exchange of confidential information between the Office of Disabilities Services (ODS) and the parties indicated. Once completed, this form and a notation concerning the persons or agencies with whom information was exchanged shall be included in the student's ODS file.

**I authorize an exchange of information between ODS and:**

(Student Initial by all Applicable boxes)

\_\_\_\_\_ ☐ Parent / Guardian(s) \_\_\_\_\_

\_\_\_\_\_ ☐ Academic advisor \_\_\_\_\_

\_\_\_\_\_ ☐ Course instructors \_\_\_\_\_

\_\_\_\_\_ ☐ Athletic coach &/or Athletic trainer \_\_\_\_\_

\_\_\_\_\_ ☐ Athletic advisor \_\_\_\_\_

\_\_\_\_\_ ☐ Post physician \_\_\_\_\_

\_\_\_\_\_ ☐ Other \_\_\_\_\_

The nature and purpose of the information to be disclosed includes the following: documentation of disability; history and severity of disability; recommendations and accommodations regarding disability; impact of disability on academic functioning; diagnosis and relevant medical history; and information related to continuity of care.

I understand that I am giving my permission to ODS to exchange confidential information. I also understand that I have the right to revoke this consent but that my revocation is not effective until delivered in writing to ODS.

This consent will remain valid until (date): \_\_\_\_\_

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Signature

\_\_\_\_\_  
VMI ID #

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness Signature

\_\_\_\_\_  
Date

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