

Disability Services
(660) 785-4478
(660) 785-4011 fax



McKinney Building
100 East Normal
Kirksville, MO 63501

Informed Consent and Authorization to Exchange Information

Disability Services (DS) at Truman State University understands the importance of privacy and that the documentation necessary to request accommodations often contains medical and/or psychological information of a sensitive nature. Your file is protected by the Family Education Right to Privacy Act (FERPA) and we are prohibited by that law to disclose your information to individuals or groups outside of Truman State University without your permission to do so. FERPA, however, allows the disclosure of parts of your record to individuals and offices within the University who have “an educational need to know.” In respect for your privacy, we wish to disclose to you what entities at Truman may have access to your information, what information will be shared and why it is necessary for those entities to have access to your information. We will also ask for your permission to exchange information with entities outside of the University if you determine that it is in your best interest for those exchanges of information to occur.

In order to provide the information necessary to entities on campus who will be assisting in providing you the agreed upon accommodations, information regarding the accommodations required will be disclosed to the relevant offices and individuals. This disclosure will typically include faculty, academic advisors, and academic support services for academic accommodations but may also include various academic administrators. For physical accommodations, this may include Residence Life and other offices and individuals who have responsibilities for facilities on campus.

In order to provide appropriate supervision for the Director of Disability Services and to ensure quality of services, the Vice President for Student Affairs may review your complete file periodically. The Vice President for Student Affairs supervises Disability Services.

Your signature below indicates that you understand your privacy rights and what University personnel may have access to the information you provide DS. *This permission will expire when you are no longer receiving DS services.*

Student Signature

Date

In addition, I give DS permission to exchange information with those clinicians that provided documentation and/or who are involved with providing my treatment, in order to determine my eligibility for accommodations. This permission includes the following individuals:

Name:

Contact Information:

This permission can be revoked at any time with the submission of a written and signed request.

Student's Signature

Date

Disability Services Director Signature

Date