Housing, Dining, and Parking Accommodation Release

Part A: TO BE COMPLETED BY STUDENT

Family/Last Name: _____ **First Name:** _____

Student ID: _____ **Phone:** _____

Date of Birth: _____ **Semester of Request:** _____

Please Describe your specific request:

I do hereby authorize the release of records and/or information with no limitation, which may include treatment for psychiatric illness, alcohol or drug abuse and/or HIV test results or AIDS/ARC diagnosis. I understand this authorization may be revoked by me at anytime and in any event, automatically expires 60 days from this date.

_____

Signature of Student/Date

Part B: To be completed by LICENSED MEDICAL/PSYCHOLOGICAL PROFESSIONAL

Please answer the following questions on letterhead and include signature and date.

- Please identify the current diagnosis for which you are making recommendations.
- Please be specific regarding the medical necessity of each recommendation request.

Return information

This form should be returned to the Office of Learning Resources via fax (937-229-3270), email: disabilityservices@udayton.edu), hand deliver (Room 023 Roesch Library) or mail (University of Dayton, Attention Office of Learning Resources, 300 College Park, Dayton Ohio 45469-1302)