SUFFOLK UNIVERSITY BOSTON

OFFICE OF DISABILITY SERVICES

AUTHORIZATION FOR RELEASE OF PERSONAL INFORMATION/EDUCATION RECORDS

I, _____, understand that my consent is required by the Family Education Rights Privacy Act of 1974, for Suffolk University to release any personally indefinable information from my education records.

I therefore, give my permission to: **The Office of Disability Services**

to _____

(IDENTIFY INDIVIDUAL(S) RECEIVING INFORMATION TO BE RELEASED)

for the purpose of _____

_____

I understand I have a right to revoke this authorization at any time by sending such written notification to _____. This authorization will automatically expire on my graduation date.

I understand further that (1) I have the right not to consent to the release of my education records; (2) I have the right to review such records upon request; (3) I have the right to request the amendment of records if I believe they are inaccurate; and (4) If my request for an amendment is rejected, I have the right to place a statement in the records explaining my position.

_____ _____

PRINT STUDENT NAME **SUFFOLK ID#**

_____ _____

STUDENT SIGNATURE **DATE**

RETURN FORM TO:

SUFFOLK UNIVERSITY, DISABILITY SERVICES
73 TREMONT STREET, 9TH FLOOR BOSTON MA 02108
disabilityservices@suffolk.edu or FAX: 617-994-6812