UNIVERISTY OF BALTIMORE
DISABILITY SUPPORT SERVICES OFFICE
1420 N. Charles Street
Baltimore, Maryland 21201-5779
410-837-4775

CONSENT TO DISCLOSE CONFIDENTIAL INFORMATION

I,_____, authorize the University of Baltimore's Disability Support Services Office (DSS) to discuss certain confidential information concerning my academic progress and medical condition to:

NAME:_____

ADDRESS:_____

Cont'd:_____

PHONE:_____

Purpose of disclosure:
_____

My signature indicates I have read this form and/or have it read to me. I know what information is to be disclosed and am aware of all consequences related to disclosure of the material.

I am able to revoke this consent (in writing) at any time. This consent form remains in effect unless revoked by me in writing.

Client's name (printed)_____

Client's signature _____Date_____

DSS Director's signature_____Date_____