

WAIVER OF DISABILITY PRIVACY RIGHTS

I, _____, authorize reasonable disclosures by the Office of Academic Support of Liberty University School of Law of my medical history and treatment information which relate specifically to my claimed disability, and which I or my medical care providers have willingly and lawfully provided to the Office of Academic Support of Liberty University School of Law. I authorize disclosure only to the teaching staff of classes in which I am enrolled at the time this waiver was made, and only for the purpose of addressing a potential disability accommodation for those classes. I understand and acknowledge that I am knowingly and voluntarily waiving my right to have my claimed disability kept private, a right granted to me as a person claiming disability under the Americans with Disabilities Act.¹ This waiver shall be valid only during the semester in which it was signed and shall expire on the last calendar day of final exams for said semester. Furthermore, I understand that making this waiver does not guarantee that any accommodation I have requested will be given to me and that Liberty University School of Law does not recognize me as a disabled person until I have established my disability and made a formal request for accommodation in accordance with the Liberty University School of Law Student Handbook.

By my signature below, I acknowledge that I have read and understood the foregoing and that I voluntarily waive my right to privacy granted to me as a person claiming disability under the Americans with Disabilities Act.¹

Printed Name of Student Making Waiver

Semester of Waiver

Signature of Student Making Waiver

Date

Witness

Date

Director of Academic Support

Date