LIBERTY UNIVERSITY | SCHOOL of LAW

WAIVER OF PRIVACY OF MEDICAL INFORMATION

I, _____, authorize reasonable disclosures by the Office of Academic Support of Liberty University School of Law of my medical history and treatment information 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 so that faculty and/or staff may be aware of my condition. I understand that I am waiving my right of privacy of my medical history, treatment information, and the diagnosis of my medical condition(s). I acknowledge that I am not seeking disability accommodation by permitting such disclosures, although I retain the right to do so in the future. I further understand 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 as it is described above.

_____	_____
Printed Name of Student Making Waiver	Semester of Waiver
_____	_____
Signature of Student Making Waiver	Date
_____	_____
Witness	Date
_____	_____
Director of Academic Support	Date