



WAIVER OF DISABILITY PRIVACY RIGHTS

I, _____, authorize reasonable disclosures by the Office of Medical Education at Liberty University College of Osteopathic Medicine 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 Medical Education. 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 academic year for which it is designated and shall expire on the last calendar day of final exams for said academic year.

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 College of Osteopathic Medicine 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 College of Osteopathic Medicine Student Handbook.

By my signature below, I acknowledge that I have read and understand 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

Academic Year of Waiver

Signature of Student Making Waiver

Date

Senior Associate Dean of Academic Affairs

Date

¹42 U.S.C. §§12101-12213 (1994).