LIBERTY UNIVERSITY | COLLEGE of OSTEOPATHIC MEDICINE

WAIVER OF PRIVACY OF MEDICAL INFORMATION

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 I or my medical care providers have willingly and lawfully provided to the Office of Medical Education. 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 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.

By my signature below, I acknowledge that I have read and understand the foregoing and that I voluntarily waive my right to privacy as it is described above.

_____	_____
Printed Name of Student Making Waiver	Academic Year of Waiver
_____	_____
Signature of Student Making Waiver	Date
_____	_____
Senior Associate Dean of Academic Affairs	Date

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