

BAYLOR

U N I V E R S I T Y

CONSENT WAIVER AND RELEASE OF MEDICAL DOCUMENTATION

OFFICE OF ACCESS AND LEARNING ACCOMMODATION

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NAME: _____ ID NUMBER: _____

SIGNATURE: _____ DATE OF BIRTH: _____

CURRENT ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CURRENT PHONE #: _____ CURRENT EMAIL: _____

PLEASE SEND MY INFORMATION TO: (CHECK FAX OR MAIL) MAIL FAX

RECIPIENT: _____

STREET ADDRESS: _____

CITY, STATE, ZIP, COUNTRY: _____

TELEPHONE: _____ FAX: _____

ITEMS TO BE SENT:

MEDICAL DOCUMENTATION COPY OF ACCOMMODATIONS BOTH

PLEASE SEND AN ADDITIONAL COPY TO REQUESTOR AT CURRENT ADDRESS ABOVE

*IF RECORDS NEED TO BE SENT TO MULTIPLE LOCATIONS, PLEASE FILL OUT AN ADDITIONAL FORM

PURPOSE FOR RELEASE: MEDICAL PROVIDER ANOTHER INSTITUTION OTHER _____

FOR OFFICE USE ONLY-- RECEIVED: _____ PROCESSED: _____