Stony Brook University
School of Medicine

Academic Policy and Procedures
Office of Medical Education

STUDENT CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

- I have read the School of Medicine policies and procedures for psycho educational testing and for disabilities accommodations.
- I authorize the Office of the Dean to receive a copy of any testing report and a copy of the DSS accommodations notification letter, if any. I understand it will be placed in the confidential section of my student record.
- I understand that if I am diagnosed to have a disability which affects my academic performance, I have to personally request appropriate accommodations through the Office of Disabilities.
- I hereby grant permission for communication between the professional staff in the Dean's Office and the professional staff of The Psychological Center SUNY at Stony Brook and the Disabilities Support Services office regarding my psychological, medical, psychiatric, educational and social records.

_____

Student's Name (Please print)

_____

(Signature of student)

Witness's name:_____

(Please print name)

_____

(Signature)