



CONSENT AND AUTHORIZATION TO DISCLOSE DISABILITY(IES) INFORMATION

In order to provide reasonable accommodation, it is sometimes necessary to discuss the documentation the student has submitted to the CST Office of Student and Community Life/Disability Services with providers such as licensed physicians, psychologists or other qualified professionals, and to discuss the student's request for accommodation with Claremont School of Theology/Bayan Claremont faculty and professional staff. If a student is taking coursework through cross-registration at Claremont Graduate University, Academy of Jewish Religion/California, University of the West, Pitzer College, Pomona College, or Bloy House/The Episcopal School at Claremont, and would like accommodations at these affiliated and partner schools, it is necessary to release information to their Disability Services Officer.

I hereby give permission for members of the staff of the CST Office of Student and Community Life/Disability Services, to discuss my disability and accommodations request, and to exchange information regarding the documentation I have submitted to the School with my provider(s) (physician, psychologist, or other qualified professional), and to request accommodation from Claremont School of Theology/Bayan Claremont, Claremont Graduate University, Academy of Jewish Religion/California, University of the West, Pitzer College, Pomona College, and Bloy House/The Episcopal School at Claremont's faculty and professional staff. This authorization will remain in effect for the duration of my enrollment. I understand that I may revoke this release of information privilege at any time by informing the CST Office of Student and Community Life/Disability Services. I understand that this information is desired in order to assist those who are helping with my education and request for accommodation, and that my refusal to authorize consent may result in a denial of specific accommodations. I also understand that my disability documentation will be kept on file for five years and that I should keep a copy of any records pertaining to my disability.

Printed Student Name: _____

Student Signature: _____ Date: _____