MONTCLAIR
STATE UNIVERSITY

Consent for Release of Information to Disability Resource Center

I, _____,

give my permission for

_____ to

release information pertaining to my disability. I understand

that documentation of disability is necessary in order to

determine eligibility to receive accommodations of

Montclair State University.

Student Name: _____ CWID: _____

Address (street): _____

(city) _____(state) _____ (zip) _____

Phone Number: _____

Physician's Name: _____

Address (street): _____

(city) _____(state) _____ (zip) _____

Phone Number: _____