Birthingway College of Midwifery
503-760-3131 | birthingway.edu

Disability Confidentiality Acknowledgment

Student's Legal Name:

First	MI	Last

By signing this form I acknowledge the following:

- *I understand that Birthingway needs information about my disability in order to provide services.*
- *I understand that I am responsible for reviewing my rights and responsibilities pertaining to disability access.*
- *I understand that in order for the Disability Services Coordinator to facilitate accommodations for me, she may need to consult with other College employees and share information about my condition as outlined in the Confidentiality and Release of Information section of the Student Access Handbook.*
- *I understand that signing and returning this form is only an acknowledgment of the confidentiality of my information, not a permission slip to share my information.*
- *I understand that if I specifically do not want the Disability Services Coordinator to share any information about my disability or accommodations, that I will need to submit a letter clearly stating so and that doing so may limit the College's ability to provide services.*

_____ _____

Student Signature Date

Please return this form directly to Birthingway's Disability Services Coordinator.

Office Use Only: Received on _____.