

Langston University
Office of Student Disabilities Services
P. O. Box 1500
Langston, Oklahoma 73050

Disability Disclosure Release

I hereby authorize Langston University, its agents, employees, and assigns, to release or disseminate any information provided to the University regarding my disability or mental condition including, but not limited to, any information provided to Langston University in the form of medical records or correspondence.

Signature_____Date_____

Witness_____Date_____

