**FERPA Acknowledgement Form**

STUDENT NAME:

EMAIL:

Pursuant to your request for an accommodation, this is to advise you that Medical Student Disability Services (MSDS) may provide information about your accommodation request and disability-related needs to the following persons as deemed necessary:

* Deans
* Faculty
* Medical Student Well-Being
* Administrative staff
* Clinical preceptors

Medical Student Disability Services adheres to the confidentiality standards set by the Federal Family Educational Rights and Privacy Act (FERPA), which provides exceptions for the releases described above. Under this federal law, in some circumstances, prior written consent by the student may be required before MSDS may release disability documentation and/or records. This document will serve as written authorization for MSDS to share information as needed in order effectuate your accommodation request.

Your signature below indicates that you have read this information, that you understand the role of the above parties in implementing accommodation(s) based on your documented needs, and that you are hereby authorizing MSDS to share your accommodations-related information with the above indicated persons, and as needed, for the purpose of addressing your accommodation needs.

You understand that this authorization will be deemed effective for the duration of your status as a student, while you are studying at the University of California, San Francisco School of Medicine (UCSF) and seek the assistance of MSDS, unless you otherwise affirmatively revoke said authorization in writing.

**Please note:** To provide consent for Medical Student Disability Services to disclose information to third parties (outside the University) you must submit the Medical Student Disability Services Consent to Release Information, which may be obtained from this office.

Should you have questions about FERPA or this document, please reach out to Dr. Lisa Meeks at lisa.meeks@ucsf.edu.

Student Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_