Psychological Disability Documentation Release of Information Form

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide **current** documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and it substantially limits some major life activities, including learning. If accommodations, academic adjustments and/or auxiliary aids are being requested, the documentation provided must support the request. Appropriate accommodations will be determined based on the specific information submitted in the documentation.

Please sign this **Release of Information Form** and submit it with the required **Psychological Disability Documentation Form** completed by a qualified professional evaluator to:

Disability Services
Chippewa Valley Technical College
620 West Clairemont Avenue
Eau Claire, WI 54701
715-833-6234 • Fax: 715-833-6470

I, ______________________________________, hereby authorize the release of requested information to the Disability Services Office at Chippewa Valley Technical College for the purpose of determining my eligibility for educational accommodations. Authorization remains in effect for **one (1) year** from the date of my signature.

I understand that I have the right to refuse to sign this authorization form and it may be revoked in writing at any time prior to the disclosure of this information.

Re-disclosure Notice: The information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by HIPAA.

____ ______________________

Student Signature Date

Date of Birth ______________________________________

Psychological Disability Documentation Form

Please note that this form must be completed by a licensed physician, psychiatrist, or clinical psychologist.

Student Name: ______________________________ **DOB:** ______________

DSM IV Category

Axis I. ______ ____
Code ____

Axis II. ______ ____
Code ____

Axis III. ______ ____

Axis IV. ______ ____

Axis V. ______ ____

Date of Diagnosis: __________ Date of Last Visit: __________

How often do you regularly meet with this student? ____________

I. Does this condition interfere with any of the following major life activities?

________ walking ________ hearing ________ seeing

________ working ________ learning ________ manual tasks

II. Describe the functional limitations and/or behavioral manifestations (e.g., easily distracted, poor concentration, difficulty focusing for extended period of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panic in unfamiliar surroundings and situations, exam taking, attendance, memory, information processing, full credit load, etc.) and recommendations you have for an academic setting. (These recommendations should be based on diagnostic information and results.)

Behavioral Manifestation:	**Recommendations:**
1. ____________________________	____________________________
2. ____________________________	____________________________
3. ____________________________	____________________________
4. ____________________________	____________________________
5. ____________________________	____________________________

III. List any medication(s) prescribed and side effects being experienced:

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IV. Describe information you have concerning this student's academic strengths and weaknesses that might be helpful in making decisions as to the appropriateness of any requests for accommodations:

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Signature of licensed physician, psychiatrist, or clinical psychologist providing information is required.

Name of Licensed Professional ________________________ License # _______________
(please print)

Address _____________________________________ Phone _________________________

Signature ____________________________________ Date __________________________