Alliant International University

Systemwide Office of Accessibility
AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Student's Name: _____

SSN/ID# _____ **Date of Birth:** _____

I hereby authorize the information requested below be released to Office of Accessibility, Alliant International University.

_____ _____

Student's Signature Date

Physician or Verifying Professional: _____

Phone#: _____ **Fax#:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

The student named above is requesting services offered through this office. In order to determine eligibility and provide services, we must have verification of the student's disability. Please complete this form entirely. Include all disabilities, listing their severity, duration, and functional limitations.

The student is requesting accommodation for: _____

I verify that the above named student has the disabling condition stated below. **Please print**:

DIAGNOSIS: _____

DSM IV CODE (if applicable): _____

LEVEL OF SEVERITY: ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Partial Remission**

DURATION:

☐ **Permanent/Chronic**

☐ **Temporary (date of re-evaluation or estimated duration of disability)** _____

PLEASE DESCRIBE HOW THIS CONDITION SUBSTANTIALLY LIMITS LEARNING AND OTHER MAJOR LIFE ACTIVITIES: _____

_____

_____

PLEASE INDICATE THE APPROPRIATE REASONABLE ACCOMMODATIONS FOR THIS STUDENT: _____

_____

_____

_____ _____ _____

Signature of Licensed or Certified Professional **Print Name** **Date**

Please return this form to the Office of Accessibility.
A photocopy of this document is valid as the original.

(2012/07)

Date Sent: _____

Systemwide Office of Accessibility

AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION

TO: _____

_____

In accordance with **THE HEALTH INFORMATION PRIVACY ACCOUNTABILITY ACT (HIPAA)**, and **THE FEDERAL EDUCATION RIGHTS AND PRIVACY ACT (FERPA)**, I, _____, authorize and order that the following information requested on the attached medical release form from Alliant International University be completed in total, by an appropriate licensed professional (as applicable) and returned as soon as possible the student's campus/Office of Accessibility.

This confidential information will be used to ascertain the educational and functional limitations imposed upon me by my disability, per the requirements for academic accommodation and services under Title V of the California Educational Code, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Further, I authorize and order that the information requested on the attached form from Alliant International University be transmitted in writing, via United States Mail, facsimile, or electronically, in as expeditious a manner as possible.

This release can be revoked at any time by me with proper notification in writing, and automatically upon my completion or departure from my post secondary studies at Alliant International University I hereby authorize and order the completion of this order for medical information made by me on this day of: _____. I certify that this authorization is made of my own volition, fully in compliance with Federal and State Laws.

_____ _____

Signature of Student Printed Name of Student

Student ID #: _____ Date Signed: _____ Date of Birth: _____

Please return this form to the Office of Accessibility.

A photocopy of this document is valid as the original.

(2012/07) **Date Sent:**_____