WESTMONT

AUTHORIZATION FOR RELEASE OF INFORMATION

Dear Dr. _____

PRINT PHYSICIAN / PSYCHOLOGIST NAME

I, _____

PRINT FULL STUDENT'S NAME

give permission for the release of information about me in your possession, which attests to the existence of a severe and chronic medical condition, to the Office of Disability Services, and may be shared, as necessary with appropriate personnel from the Office of Disability Service at Westmont College.

Please provide the following information under separate cover and on practice letterhead.

The authorized release of information is to include but is not limited to the following:

- History of personal, social, medical and education activities as it pertains to the cause for evaluation.
- Diagnostic statement identifying the disability (ICD-DSM classification)
- Description of the diagnostic methodology used, including all data from appropriate evaluations instruments. Information based on "screening" instruments is not acceptable.
- Description of current substantial limitations as they relate to meeting the various demands of University life. The report should contain a discussion and evidence of impact as it relates to the actual academic achievement (or lack thereof) in current time period and past year (indicate any accommodations and/or services provide.)
- Medication – mitigation of impact and/or (expected) side effects.
- Co-morbid conditions – if multiple diagnoses are provided, please indicate primary, secondary and how each affects learning.
- Explanation of differential or exclusionary diagnosis
- Recommendations – Suggestions for accommodations should be directly linked to the impact of the disability and associated issues (e.g. medication) and not simply to the diagnosis.

_____

STUDENT'S SIGNATURE / DATE

A photocopy of this release shall be of the same force and effect as the original. Email or FAX to ods@westmont.edu, 805-565-7244. You may also mail to: 955 La Paz Rd. Santa Barbara, California 93108 Attn: Office of Disability Services