CONSENT AND AUTHORIZATION TO RELEASE INFORMATION TO STUDENT DISABILITY SERVICES

Pursuant to Federal and State law concerning my right to confidentiality and privileged communication, I, _____, hereby authorize:

_____
Person or Organization

_____
Address

_____
City, State, Zip Code

_____ _____
Phone Number Fax Number

To release the following information:

_____ Information Requested on this Verification Form

_____ Diagnosis

_____ Psych-Educational/Neuropsychological Evaluations

_____ Psychological Evaluation

_____ History of previously used accommodations

_____ Other: _____

Purpose of disclosure:

Documentation needed to request academic, dietary, and/or housing accommodations at post-secondary institution.

The information is to be provided to:

Student Disability Services, Braniff
132 University of Dallas
1845 East Northgate Drive
Irving, Texas 75062
Phone: (972) 721-5056
Fax: (972) 265-5712
Email: ada@udallas.edu

I understand this authorization for confidential information applies only to the individual named above and only for a period of 180 days and does not permit the release of information concerning me to any other individual. In addition, I understand I may revoke this consent to release information at any time, but recognize that any release made between the time I authorized it and then revoked it shall not constitute a breach of my right to confidentiality.

A photocopy or fax of this authorization shall be considered as effective and valid as the original.

Student Signature:i

○ Other (please describe):

_____

c. Severity of symptoms

○ Mild

○ Moderate

○ Severe

d. Prognosis of disorder:

○ Good

○ Fair

○ Poor

Please explain: _____

_____

3. **Functional Limitations**: ***Should be determined WITHOUT consideration of mitigating measures (i.e. medication, etc.). If condition is episodic in nature, level of functioning should be assessed based on active phase of symptoms.***

a. Does this condition significantly limit one or more of the following major life activities?

	No Impact	Moderate Issue	Substantial Impact	Don't Know
Communicating				
Concentrating				
Hearing				
Learning				
Manual Tasks				
Reading				
Seeing				
Thinking				
Walking				
Working				
Other:				

b. Please check the functional limitations or behavioral manifestations for this student:

	Not an Issue	Moderate Issue	Substantial Issue	Don’t Know
Unders				

b. Recommended accommodations. Please provide a rationale for each accommodation. In the absence of a rationale, Student Disability Services may be unable to recommend the proposed accommodation

Thank you for your help in providing this information so that we may begin services as soon as possible. Please complete the provider information below. This form should be signed and returned via fax or mail to the SDS office at the address shown at the end of this document. All documentation submitted to SDS is considered confidential.

Provider Information

I certify, by my signature below, that I conducted or formally supervised and co-signed the diagnostic assessment of the student named above.

Signature:_____Date:_____

Print name and title:_____

_____

State of License :_____ License Number: _____

Address:_____

_____

Street or P.O. Box City State Zip

Phone:_____Fax:_____

Please return this form to:

University of Dallas
Student Disability Services
Academic Success Office 1845 East
Northgate Drive Irving, Texas 75062 Phone:
(972) 721-5056 Facsimile: (972) 265-5712

[Adapted from https://diversity.utexas.edu/disability/wp-content/uploads/2018/07/Medical.VerForm-2015-Updated.pdf, with permission from ITS, The University of Texas at Austin, Austin, Texas 78712-1110.]