

**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 previouslr o-

The information below is to be completed and signed by the Provider.

1. Diagnosis: Please list all relevant diagnoses.

Visual Acuity with correction: _____ Visual
Acuity without correction: _____ a. Approximate
onset of symptoms

Child-approximate age: _____

Adolescent-approximate age: _____

Adult-approximate age: _____

Unknown

b. Date of current diagnoses: _____ / _____ / _____

c. Date of your last clinical contact with student: _____ / _____ / _____

2. Evaluation

a. How did you arrive at this diagnosis? Please check all relevant items below, adding brief notes that you think might be helpful to us as we determine eligibility for accommodations.

Medical evaluation (x-ray, lab work, EKG, etc.)

Standard eye exam.

Specialized eye exam: Specify: _____

Structured or unstructured interviews with student.

Interviews with other persons (i.e. parent, teacher, therapist).

Behavioral observations.

Other (Please specify). _____

b. Evaluation Results:

c. Present symptoms that meet criteria for diagnosis being noted:

d. Current treatment being received by student:

Medication management:

Current medications: _____

Other (please describe):

e. Severity of symptoms

Mild

Moderate

Severe

f. Prognosis of disorder:

Good (vision loss is stable)

Fair (vision loss is changing, but individual retains functional level of sight)

Poor (vision is degenerative)

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 Impact Substantial Impact Don't Know

Communicating

Concentrating

Hearing

Learning

Manual

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

Not an Issue Moderate Issue Substantial Issue Don't Know

Cognitive
Processing

Memory

Processing Speed

Meeting Deadlines

Attending class

Organization

Reasoning

Stress

Sleep

Appetite

Other:

c. Please describe in detail any functional limitations that fall into the substantial range.

d. **8.**

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

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