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-$_{r}$

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. _____

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.]