

# Medical/Educational Information Release Form

In order to receive disability-related services at Santa Monica College, a verification of disability must be provided.

Name of Physician or Agency \_\_\_\_\_

Phone number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_ Zip Code \_\_\_\_\_

I hereby request and authorize you to release to Santa Monica College any medical/educational information pertaining to me that you may have, including diagnosis, psychological testing with raw data, Individual Educational Plan (IEP), Vocational Rehabilitation Plan, and relevant medical information. I request that the professional designated above complete this form.

Signature of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Print Name \_\_\_\_\_

Signature of Parent or Guardian (if student is under 18 years old) \_\_\_\_\_

Print Name \_\_\_\_\_

## THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

The above student has requested support services through our Center for Students with Disabilities at Santa Monica College. To provide such services, we require certain information from you which will become part of the student record, and may be released to the student upon their written request. Please respond to the following questions:

### Primary Disability

1. Diagnosis \_\_\_\_\_

DSM IV Code (if applicable) \_\_\_\_\_ Date of Onset \_\_\_\_\_

Duration of Disability: Permanent \_\_\_\_\_ or temporary, how long? \_\_\_\_\_

Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms

Level of Severity

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

2. Is this student currently in treatment with you \_\_\_\_\_

And if so, when did you last see this student \_\_\_\_\_

3. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication

Side Effects

Level of Severity

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_

License Number: \_\_\_\_\_ Date: \_\_\_\_\_

Title: \_\_\_\_\_

Phone Number: \_\_\_\_\_

**Secondary Disability (if applicable)**

1. Diagnosis \_\_\_\_\_
2. DSM IV Code (if applicable) \_\_\_\_\_ Date of Onset: \_\_\_\_\_
3. Duration of Disability: Permanent \_\_\_\_\_ or temporary, how long? \_\_\_\_\_

Please indicate the major symptoms currently manifested by the student that substantially limit major life activities and will necessitate accommodation in an academic setting.

Symptoms	Level of Severity
_____	_____
_____	_____
_____	_____
_____	_____

4. Is this student currently in treatment with you \_\_\_\_\_  
And if so, when did you last see the student? \_\_\_\_\_
5. What medications are currently prescribed and what are the side effects experienced by this student that might necessitate accommodation in an academic setting?

Medication	Side Effects	Level of Severity
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature \_\_\_\_\_ License Number: \_\_\_\_\_ Date: \_\_\_\_\_  
 Title: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Please complete and upload to your CSD Online Application: **Upload Documentation** section.

Center for Students with Disabilities  
 Santa Monica College  
 1900 Pico Blvd.  
 Santa Monica, CA 90405  
 Phone: 310-434-4265

DSPS Release of Information:  
 The Santa Monica Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by the Center for Students with Disabilities Program. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of regulations, Title 5, Section 56000 et seq.

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