

**San Diego City College**  
Disability Support Programs & Services  
1313 Park Blvd.  
San Diego, CA 92101-4787

**TEL (619) 388-3513**  
**FAX (619) 388-3801**  
**TTY (619) 388-3313**

**AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION**

|  |      |
|--|------|
| <b>Student's Name:</b> _____   |      |
| <b>SS/ID#:</b> _____ <b>Birth Date:</b> _____  |      |
| <b>I hereby authorize the information requested below be released to<br/>Disability Support Programs and Services at City College.</b> |      |
| _____  |      |
| Student's Signature  | Date |

|  |
|--|
| <b>Physician or Verifying Professional:</b> _____                              |
| <b>Phone #:</b> _____ <b>Fax #:</b> _____                                      |
| <b>Address:</b> _____ <b>City:</b> _____ <b>State:</b> _____ <b>Zip:</b> _____ |

The student named above is requesting services offered through this office. In order to determine eligibility and provide services, we must have verification of the student's disability. Please complete this form entirely. Include all disabilities, listing their severity, duration, and functional limitations.

**The student is requesting accommodation for:** \_\_\_\_\_

I verify that the above named student has the disabling condition stated below.

**DIAGNOSIS:** \_\_\_\_\_

**DSM IV CODE** (if applicable): \_\_\_\_\_

**LEVEL OF SEVERITY:**     Mild     Moderate     Severe     Partial Remission

**DURATION:**

- Permanent/Chronic
- Temporary (date of re-evaluation or estimated duration of disability) \_\_\_\_\_

**PLEASE DESCRIBE HOW THIS CONDITION SUBSTANTIALLY LIMITS LEARNING AND OTHER  
MAJOR LIFE ACTIVITIES:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

|  |                   |             |
|--|-------------------|-------------|
| _____  | _____             | _____       |
| <b>Signature of Licensed or<br/>Certified Professional</b> | <b>Print Name</b> | <b>Date</b> |

Please return this form to the City College DSPS office at the address or fax number listed above.  
**A photocopy of this document is valid as the original.**



**DISABILITY SUPPORT PROGRAMS & SERVICES  
SAN DIEGO CITY COLLEGE  
AUTHORIZATION FOR RELEASE OF PRIVATE MEDICAL INFORMATION**

TO: \_\_\_\_\_

In accordance with **THE HEALTH INFORMATION PRIVACY ACCOUNTABILITY ACT (HIPAA)**, and **THE FEDERAL EDUCATION RIGHTS AND PRIVACY ACT (FERPA)**, I,

\_\_\_\_\_,  
authorize and order that the following information requested on the attached medical release form from San Diego City College, Disability Support Programs and Services be completed in total, by an appropriate licensed professional (as applicable) and returned as soon as possible to the following address or by FAX to:

San Diego City College  
1313 Park Boulevard, Rm A-115  
San Diego, CA 92101  
Attention: Barbara Mason  
Coordinator, DSPS  
Telephone: 619-388-3513  
Fax: 619-388-3801

This confidential information will be used to ascertain the educational and functional limitations imposed upon me by my disability, per the requirements for academic accommodation and services under Title V of the California Educational Code, Section 504 of the Rehabilitation Act of 1973, and the Americans with Disabilities Act of 1990. Further, I authorize and order that the information requested on the attached form from San Diego City College be transmitted in writing, via United States Mail, facsimile, or electronically, in as expeditious a manner as possible.

This release can be revoked at any time by me with proper notification in writing, and automatically upon my completion or departure from my post secondary studies at San Diego City College.

I hereby authorize and order the completion of this order for medical information made by me on this day of: \_\_\_\_\_. I certify that this authorization is made of my own volition, fully in compliance with Federal and State Laws.

\_\_\_\_\_  
Signature of Student

\_\_\_\_\_  
Printed Name of Student

Date Signed: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Last Four Digits of Social Security Number: \_\_\_\_\_