University of Evansville

Office of Counseling Services
1800 Lincoln Avenue ■ Evansville, Indiana 47722
812-488-2663

AUTHORIZATION TO RELEASE INFORMATION – STUDENT COMPLETES

Student Name:_____ UE ID#:_____ Birth Date:_____

I am requesting disability accommodations through Disability Services at the University of Evansville. The school requires current and comprehensive documentation of my disability/medical condition as one of the criteria used to evaluate eligibility for disability-related accommodations. Please respond to the following questions as soon as possible and return to me or send to Disability Services by email. I authorize Disability Services to contact you if clarification is needed.

Student Signature: _____ Date: _____

INFORMATION BELOW TO BE COMPLETED BY TREATING PRACTITIONER

Today's Date: _____

Healthcare provider name (print): _____

Title: _____ Phone: _____

Organization and address: _____

1. Diagnosis(es) and date(s): Include ICD/DSM diagnoses and/or code

   _____

   _____

   _____

2. Is this student currently under your care? _____Yes _____No

3. Current Status of condition(s) (e.g. active, progressing, controlled, in remission, temporary):

   _____

   _____

4. Current level of severity (choose one): Mild Moderate Severe

5. How long is this condition(s) likely to persist (be as specific as possible – e.g., lifetime; 1 academic year; duration of academic program enrollment; 1 month)

   _____

   _____

6. List procedures/assessments used to diagnose this student's condition:

_____

_____-

7. What are the functional limitations or symptoms of the condition(s)?

_____

_____

_____

8. What exacerbates this student's specific disability (ies)? (Please be as specific and detailed as possible)

_____

_____

_____

9. Describe the impact of the diagnosis on the student's academic functioning (test taking, reading, processing information, attendance, etc.)?

_____

_____

_____

10. Identify any accommodations you believe are necessary in order for the student to participate in the university's programs, activities, and services.

_____

_____

_____

This information is current and accurate to the best of my knowledge based on my recent evaluation of this patient or my review of records of a recent evaluation by a qualified healthcare provider.

Signature of Treatment Provider: _____

License #: _____

Date: _____

Return the completed form to Disability Services at disabilityservices@evansville.edu. Please call 812-488-2663 if you require additional information. Feel free to attach any additional reports or relevant information. All information on this form will remain confidential in accordance with the Family Educational Rights and Privacy Act (FERPA)