SANTA BARBARA CITY COLLEGE
Disabled Student Programs & Services

Student Authorization for Release of Disability Verification

Name: _____ K#: _____

DOB: _____/_____/_____ Phone: (_____)_____

Today's Date: _____/_____/_____

Student, please complete:

I hereby authorize the release of information requested in this document to DSPS and further authorize DSPS to communicate with the named individual or agency identified below to obtain clarification, as needed, to determine my eligibility for disability services at Santa Barbara City College (SBCC). *This authorization for release of information is valid for 6 months.*

Additionally, I have read and understand the DSPS Release of Information below.

DSPS Release of Information

1. Disability-related documents created by a California Community College will only be released to an outside party with the written consent of the student (per FERPA). These documents may include, but are not limited to: California Community College Learning Disabilities Assessment (from SBCC or another California Community College), a listing of SBCC-approved academic accommodations, and/or the student's DSPS Academic Accommodation Plan from SBCC.
2. **DSPS will not re-release documents originating from agencies, organizations, or individuals to the student or other parties.** Therefore, students submitting third-party documentation (i.e. medical records, diagnostic reports, IEP's, 504 Plans, etc.) should maintain personal copies for future use.

☞ On the bottom of page 2, **please indicate to whom you would like this request returned to.**

Signature of Student: _____ Date: _____

Licensed/Certified Professional, please complete:

Disabled Student Programs & Services (DSPS) provides academic services and accommodations to students with diagnosed disabilities. To be eligible for these services, students must present documentation of their condition(s) so DSPS may determine their eligibility for services as defined by federal and state statutes. Your assistance in providing the information requested in this form will help determine reasonable academic accommodations. *Please write legibly.* *Illegible forms will delay the documentation review process for the student.*

(Continued on reverse)

Licensed/Certified Professional *(continued):*

1. Diagnosis(es):_____
_____

If applicable: ❑ DSM-IV ❑ DSM-5 Code(s): _____ Severity: _____

Dates of diagnosis(es):_____

Date of last contact with student: _____/_____/_____

2. This condition is: ❑ Chronic/Permanent ❑ Temporary (estimated duration:_____)

3. Identify functional limitations of diagnosis(es) (e.g. dexterity, stamina, concentration, processing): _____
_____
_____
_____
_____

4. Describe the patient's current symptoms, current medications and side effects, and any situation and/or environmental triggers that could exacerbate the condition: _____
_____
_____
_____

Name of Professional: _____
License # :_____
Title:_____
Phone: (_____)_____
Address:_____
_____

My signature acknowledges that I am licensed to verify/diagnose the diagnosis(es) documented above.
Signature: _____ Date:_____

- **Please attach relevant reports** (e.g. psychological, vision, psycho-educational, audiological)
- **Please return this form and any relevant reports to:**
  *(**Student**, indicate to whom this completed request should be given to by initiating below)*
  _____ Student/Requestor
  _____ DSPS · Santa Barbara City College · 721 Cliff Dr. · 93109
  Phone (805) 730-4164 · Fax (805) 884-4966