ANTIOCH UNIVERSITY
NEW ENGLAND
Office of Student Disability Services | 40 Avon Street, Keene, NH 03431-3516 | 603-357-3122 | www.antiochne.edu

Consent for Release of Medical, Psychological, or Educational Assessment Information

Name and Address of Person(s) Providing Documentation of Disability Diagnosis and Recommendations for Accommodations

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I, ____________________________, hereby authorize ______________________________, to release information to Fran Ziperstein, Director of Student Disability Services at Antioch University New England, any and all information that is relevant to my disability of ____ ____________________________, and the functional limitations imposed by my disability.

I desire that you disclose all materials that may be relevant to the determination of whether I have a disability, the extent of the impairment, and possible accommodation(s) with a rationale for the recommendations.

In consideration for the act of providing this information, I agree to release the person or entity named above and his/her agent from all legal responsibility and legal liability for any damage whatsoever resulting from the furnishing of this personal information. I promise not to make any complaint, legal or otherwise, because of any information, written or oral, released by the above listed person, organization or his or her agents.

____ ______________

Student Signature Date

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To Whom It May Concern:

A patient or client of yours is enrolled in a graduate-level degree program at Antioch University New England has requested disability related services. Legal protection and eligibility for such services are based on the student providing sufficient information so that we may determine that he or she has an impairment that **substanially limits** one or more major life activity. As our student's treating specialist, please provide the following information to allow us to evaluate the student's service requests.

1. Patient/Client Name ____

2. Condition of Patient/Client

A. What is the diagnosis of the impairment?

B. When was this diagnosis originally made?

C. Is the patient/client currently under your care?

D. When did you last see the client?

E. Is the impairment temporary (<3 months) or persistent?

F. Please identify any factors affecting the severity of the impairment, including ways the impact could be minimized, or alternatively, exacerbated (e.g. medication side effects)?

3. Please completed the following **Functional Impact Assessment**

1. Unable to Determine **2. Mild** **3. Substantial**

1	2	3	Major Life Activity		1	2	3	Major Life Activity
			Caring for Oneself					Interacting w Others
			Talking					Learning
			Hearing					• Reading
			Breathing					• Writing/ Spelling
			Seeing					• Calculating
			Walking or Standing					• Memorizing
			Lifting/ Carrying					• Concentrating
			Sitting					• Listening
			Doing Manual Tasks					Other: (specify)
			Eating					
			Working (employment)					
			Sleeping					

4. What methods were used to assess the client's functional limitations **Please attach report (e.g. psycho-educational assessment report.)**

5. Please list any recommendations for accommodations at the university. Provide a rationale for each recommendation, using data from objective measures, the client's educational record, or other sources. Please list or attach to this form.

6. **Certifier Information**

Clinician Name ____

Medical/Psychological Specialty ____

License ______________________________ Email __________________ ___________

Address ____ ____

Signature ____ Date ________________

Please return the completed form and evaluation report to: Fran Ziperstein, Director of Student Disability Services, Antioch University New England, 40 Avon St, Keene, NH 03431. Email: fziperstein@antioch.edu. Fax 603 357-0718. Please feel free to contact me if you have any questions. Thank you.