MEDICAL AUTHORIZATION RELEASE

TO THE PHYSICIAN, PSYCHOLOGIST, AUDIOLOGIST, DIAGNOSTICIAN, OR PRACTITIONER: The student has informed EL PASO COMMUNITY COLLEGE CENTER FOR STUDENTS WITH DISABILITIES that his/her condition has prevented or will prevent him/her from performing essential academic functions and or attending classes regularly unless special services are provided. We would appreciate receiving sufficient information from you in order to determine appropriate accommodations in accordance with state and federal laws. For example: 1) for a learning disability, a full diagnostic evaluation is required from a licensed psychologist or psychiatrist or educational diagnostician; 2) for a hearing disability, a current audiogram from an ENT or Audiologist is required; 3) for a psychological disability, a diagnosis based on a current DSM from a licensed psychologist/psychiatrist will be required; and, 4) for a physical disability according to the current ICD from a physician will be required.

1. Please provide a diagnosis of condition or brief description of disability. ____________________________________________
   __________________________________________________________________________________________
   _________________________________________________________________________________________

2. How was this diagnosis determined? __________________________________________________________________________
   _________________________________________________________________________________________

3. Prognosis: The condition is ☐ Permanent ☐ Temporary; how long: _________________ Subject to change? ☐Yes ☐No

4. Is condition: ☐ Under Control ☐ Not under Control

5. When was the student first seen by you for this condition? ______________________________
   Is the student currently under your care? ☐ Yes ☐ No Month/Day/Year __________________________

6. Can the student perform essential academic functions without threat to health/safety of: Self ☐Yes ☐No If no, please explain: _________________________________________________________________________________________

7. What are typical accommodations needed for disabilities of this nature? ______________________________
   _________________________________________________________________________________________

_____________________________________________________________________________________________

Updated 6/2010
8. What are the specific functional abilities and limitations (e.g. Mobility or other classroom or test situations, sitting, rest breaks, environmental conditions, medically-related absences, equipment modifications, etc.) should the College consider in determining the reasonable accommodation(s) that will enable the student to perform essential academic functions?

_____________________________________________________________________________________________________

9. Are there any side effects from medication, which might affect academic performance? ☐ Yes ☐ No

If yes, please describe: ____________________________________________

10. Class attendance is frequently an essential function; does the condition affect the student’s class attendance? ☐ Yes ☐ No

If yes, please explain how: __________________________________________

I hereby certify that the information provided above is true and correct to the best of my knowledge

_____________________________________________________________________________________________________

Practitioner’s Signature ____________________________ / ________ / ________ Date ____________________________ / ________ / ________ Year

Print Name ____________________________ Degree/Specialty ____________________________

Street ____________________________ Telephone # ____________________________

City ____________________________ State ____________________________ Zip ____________________________

License Number ____________________________

I, ________________________________________________________, Social Security Number __________ / ________ / ________

authorize the release of the above information to: El Paso Community College, Center for Students with Disabilities. Student

Signature ____________________________ Date ________ / ________ / ________