

Program: _____
Site: _____
Date In: _____
Date Out: _____

Status: _____
Quarter: _____



FOOTHILL COLLEGE
12345 El Monte Road
Los Altos Hills, CA 94022
www.foothill.edu/al

ADAPTIVE LEARNING DIVISION (ALD)
DISABILITY RESOURCE CENTER (DRC)
Phone: (650) 949-7017/7102
Fax: (650) 917-1064, Room 5801

RELEASE OF INFORMATION

Student Name: _____
First **Last**

SID#: _____ **Date of Birth:** _____

Medical Record #: _____

I hereby authorize the release of information from the Physician or verifying professional stated below to Foothill College Adaptive Learning Division Disability Resource Center regarding my disability and/or functional limitation. All information will be kept confidential and maintained as part of my records with the California Community College Adaptive Learning Division and Disability Resource Center. I authorize the release of information to include one or more of the following records:

- Diagnosis signed by an appropriate medical practitioner or psychologist
 - Psychological testing and evaluation results
 - Vocational Rehabilitation Plan
 - Individualized Education Plan (IEP)
 - Detailed results of assessment, psychological or medical testing that led to the diagnosis
 - Other: _____
- _____
- _____

Name of Treating Physician or Verifying Professional: _____

Address: _____
Street **Apt #** **City** **Zip**

Phone #: _____

Student Signature: _____ **Date:** _____

A photocopy of this document is as valid as the original. This authorization shall remain in effect until revoked in writing by the student.