Student Authorization for Release of Information
For Academic Accommodations

The faculty and staff of Bethany College wish to work with you toward a positive educational experience while at Bethany. In order to do this, we need your assistance in letting us know if you have special needs. In order to support you effectively, we ask you to sign this release of information, which will allow us to communicate with appropriate people to coordinate services to meet your needs in a proactive manner, as accommodations are not retroactive. Please fill out this form and return it to:

Cynthia FitzGerald, M.A., A.B.S., Director of Educational Support Services
800 Bethany Drive
Scotts Valley, CA. 95066
FAX: 831/439-9983

Note: Please sign and send the *Authorization for Release of Information By Licensed Physician Or Health/Education Professional* form to your health care professional for required verification. This should be submitted with the appropriate documentation of your disability, such as diagnostic testing assessments and summaries with accommodation recommendations.

Please provide the following:
Student's Name:
Date of Birth: Social Security Number:
Permanent Address:
Class Level:

Disability is ____Permanent or ___Temporary (If temporary, note anticipated duration of condition: ____)
Please indicate any past academic accommodations that you have received:

I hereby give the Director of Educational Support Services permission to share this information with the following people/agencies:
___ All agencies &/or people with legitimate educational need to know
Or check specific groups with whom this information may be shared:
___ Faculty, according to your scheduled courses
___ College Personnel, including Registrar, Financial Aid Director, Dean of Students, Resident Director as needed
___ Parent (s) (Names: ____)
___ Previous Educational Institutions
___ Others (State names or agencies: ____)

I understand and agree that I am giving authorization for the Director of Educational Support Services to share this information with the above people.
Student's Signature____ Date ___________
I understand that I must have documentation of my disability on file with the Director of Educational Support Services to be eligible for services and accommodation recommendations.
Student's Signature ____Date____________

THIS CONFIDENTIAL FORM IS FOR DSS USE ONLY-
DISABILITY CATEGORY: __*VISION*__ *MOBILITY*__ HEARING__ SPEECH__ LD
OTHER/DESCRIBE:

Authorization for Release of Information
By Licensed Physician Or Health/Education Professional

To: (Professional)
(Address)
(City, State, Zip)

Telephone: FAX:
E-mail:

I, the undersigned student, am requesting special services from Bethany College and hereby request and authorize you to release any information pertaining to my disability, including history, test results, summaries and recommendations.
Student's Name:`
Date of Birth: Social Security #:
Phone/Cell: Email:
Student's Signature: ____Date____________

DISABILITY VERIFICATION

In order to provide the student with accommodations designed to help him/her to be more successful in college, we require verification of the student's disability (medical, educational, psychological). Please provide the following information:
Diagnosis: NOTE PRIMARY/SECONDARY OR AXIS I, II, III, IV, V

Date and age of student when initially diagnosed:

Please note any functional limitations resulting from the disability/disorder that would, in your opinion, impede the student's educational performance. Check all that apply:
__Poor concentration, distractibility &/or confusion
__Intense anxiety, phobia, &/or panic that would impact completing orientation or registration process due to crowds, decision making, &/or long lines.
__Difficulty completing assignments due to pressures
__Difficulty in taking notes, reading college texts, taking exams
__Problems in hearing, seeing or speaking in class during lectures & discussions
__Other concerns impacting the student in a college setting. Please describe:
Please give an explanation for those items checked:

Professional's Signature:____Date____________
Professional's Title:____

After a qualified professional has completed the Disability Verification section, please send this form to:

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Bethany College
800 Bethany Drive
Scotts Valley, CA. 95066.
FAX 831/439-9983 Phone 831/438-3800 ext.3946

She will work with Dr. Flowers, Vice President of Academics, as well as with the appropriate faculty and staff, to help support the student.