SAMPSON COMMUNITY COLLEGE
P.O. Box 318
Clinton, NC 28329

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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

DISABILITY SERVICES

Provider: _____

Attention: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone Number: _____ **Fax Number:** _____

I, _____(full name), Date of Birth: _____
Last 4-digits of Social Security #:_____ give my permission for the release of educational, psychological, medical, vocational, audiology, visual, or any information about me in your possession, which attests to the existence of a disabling condition, to Disability Services at Sampson Community College. The said condition may restrict access to educational programs and activities unless reasonable accommodations are provided; thus, the information may be used to evaluate the need for such accommodations and to implement the planning of an educational program. I understand that my records are protected by law and cannot be disclosed without my written consent unless otherwise provided in the regulations. I understand that I may revoke this consent at any time except to the extent that action has already been taken. This authority expires with the completion of all transactions related to services provided by Sampson Community College unless otherwise specified.

Please provide the following information under separate cover on **practice letterhead with the signature of the Physician, Psychologist, or Specialist.** The authorized release of information is to include but is not limited to the following:

1. **Presenting diagnosis** utilizing diagnostic categorization or classification of the ICD or DSMV. Diagnoses should indicate primary, secondary, etc., and significant findings, particularly with respect to presenting problems.
2. **Date the examination/assessment/evaluation** was performed for the presenting diagnosis; or if following the student for an extended time, date of onset and date of an evaluation of the condition that is recent enough to demonstrate the student's current level of functioning.
3. **Test, methodology used** to determine disability.
4. **Identify limitations** in function or performance as they pertain to one more of the following major life activities: caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working. Is this condition permanent or temporary? If temporary, what is the expected length of time to recovery?
5. **Is/was medication prescribed?** What is the frequency? Are any physical and/or cognitive processes affected by the medication? If so, how?

Student Signature: _____ **Date:** _____

Parent Signature: _____ **Date:** _____
(*only students under 18 years old)*

Coordinator of Special Populations Signature: _____ **Date:** _____

RETURN TO: Sampson Community College, Attn: Coordinator of Special Populations, PO Box 318, Clinton, NC, 28329
-OR- Secure Fax: 910-900-4399