Dean of Students Office
One Cumberland Square
Lebanon, TN 37087
(615) 547-1353

Authorization for Release and Exchange of Information
Between the Office of Disability Services and Healthcare Provider

Name: _____ Social Security Number: _____

Date of Birth: _____

By signing below, I hereby authorize Lisa Macke of the Cumberland University Office of Disability services to exchange the following information with my healthcare provider:

Name: _____

Of: _____

Address_____

_____

_____

_____Date of Assessment and Diagnosis
_____Current Impact of Disability and Limitations on Academic Performance
_____Treatments and Medications in Current Use
_____Estimated Effectiveness of Treatments or Medications in Lessening the Impact of Disability
_____Expected Duration, Stability, or Progression of the Condition
_____Clinical Summary of Procedures and Instruments Used to Make the Diagnosis
_____Diagnostic Interview and/or Testing Results
_____Specific Recommended Academic Accommodations With Rationale for Each Recommendation
_____Complete DSM-IV-TR Diagnosis in Multi-axial Format, Current Symptoms
_____Other:_____

Limitations, if any:

_____

_____

I understand that this information will be exchanged to provide quality care and to better coordinate services. I understand that I may revoke this consent at any time by notifying the parties involved in writing. I sign this form voluntarily and understand that this authorization will automatically expire one year from this date. If I choose not to sign this authorization, I understand that my refusal to sign this form will result in the information NOT being exchanged and that this may have an impact on the ability to receive special accommodations under ADA at Cumberland University.

Signature: _____ Date: _____