COLLEGE OF THE SISKIYOUS

DSPS RELEASE OF INFORMATION

Disabled Students Program and Services

The student named below has requested services/accommodations through **DSPS**. In order to assist him/her, we must have the information checked below.

Treating Physician/Verifying Professional: _____

Address: _____City _____ State: _____ Zip_____

Phone Number:_____ Fax:_____

Dates of Treatment/School Attendance:_____ to_____

Treating Physician/Verifying Professional: _____

Address: _____City _____ State: _____ Zip_____

Phone Number:_____ Fax:_____

Dates of Treatment/School Attendance:_____ to_____

Name of Student: _____*SS#/ID#: _____

Other Names Used: _____ Date of Birth: _____

I authorize the release of information from my Treating Physician/Verifying Professional regarding my disability(ies) to College of the Siskiyous **DSPS**. All information will be kept confidential and maintained as a part of my records with the California Community College **DSPS** Office. I authorize the release of information to include one or more of the following records identified below:

- ☐ Diagnosis of disability signed by appropriate medical practitioner or psychologist.
- ☐ Psychological Testing and evaluation results.
- ☐ Vocational Rehabilitation Plan
- ☐ Individual Education Plan (IEP)
- ☐ Detailed results of assessment, psychological, or medical testing that led to the diagnosis.
- ☐ School Transcripts
- ☐ Other: _____

I further give permission for **DSPS** certificated program staff to discuss my educational situation with other Professionals who have a legitimate educational need to know. _____
Initials

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

Signature of Student:_____Date: _____

The Community College District uses the information requested on this form for the purpose of determining a student's eligibility to receive authorized special services provided by DSPS. Personal information recorded on this form will be kept confidential in order to protect against unauthorized disclosure. Portions of this information may be shared with the Chancellor's Office of the California Community Colleges or other state or federal agencies; however, disclosure to these parties is made in strict accordance with applicable statutes regarding confidentiality, including the Family Educational Rights and Privacy Act (20 U.S.C. 1232(g)). Pursuant to Section 7 of the Federal Privacy Act (Public Law 93-579; 5 U.S.C. § 552a, note), providing your social security number is voluntary. The information on this form is being collected pursuant to California Education Code Sections 67310-67312, and 84850; and California Code of Regulations, Title 5, Section 56000 et seq.