## RELEASE OF INFORMATION AUTHORIZATION

By completing this Release of Information Authorization, I, _____, authorize the Student Support and Accessibility Program Office to contact the provider(s) listed below for the express purpose of obtaining clarification necessary to evaluate my request for student housing accommodation.

**Authorization to Release Health Care Information**. I authorize the provider(s) listed below to release information related to my request for student housing accommodation due to a chronic health condition or disability and to discuss this request as necessary. I understand that such information may include my diagnosis, prognosis, treatment history and/or functional limitations.

Provider Name:
_____

Provider Title:
_____

Provider Address:
_____

City:_____State:_____Zip Code: _____

Telephone Number: _____ Fax Number: _____

Provider Name:
_____

Provider Title:
_____

Provider Address:
_____

City: _____State: _____Zip Code: _____

Telephone Number: _____ Fax Number: _____

I understand that providing false, misleading, or incomplete information may lead to disciplinary action or the denial of my request for student housing accommodation.

Student Signature (or parent/guardian signature if under 18)
_____ Date: _____

**DOCUMENTATION OF ACCOMMODATION NEEDS**

Students requesting accommodations due to a disability or chronic health condition must provide documentation from a licensed medical or mental health provider who is treating or has treated the student within the preceding three (3) years. To assist Lindenwood University's Student Support and Accessibility Program Office in assessing the student's request for a accommodation, please complete this form and return it to accessibility@lindenwood.edu

Please refer to the following definitions when completing this form:

| |
|---|
| **Disability**: A physical or mental impairment that substantially limits one or more major life activities. |
| **Major life activity**: Includes but is not limited to the operation of a major bodily function (e.g., immune system, digestive system, bowel, neurological, respiratory, endocrine, lymphatic, musculoskeletal, reproductive), caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, and working. |

1. Please describe the diagnosis/es related to the student's disability:
   _____
   _____
   _____
   _____
2. Initial date of diagnosis:
   _____
3. Please describe how the student's diagnosis/es substantially limits one or more major life activities:
   _____
   _____
   _____
4. Please list recommendations for medically necessary accommodations. Please be sure to explain why the accommodations are medically necessary as they relate to the diagnosed conditions and/or associated disability.
   _____
   _____
   _____
5. Please indicate the basis for your recommendation(s). Check all that apply:

   ☐ Student/parent/guardian request
   ☐ Clinical assessment that revealed the need for the requested accommodation
   ☐ Consensus reached through discussion between clinician and student
   ☐ Other (please explain) _____

Printed Name: _____ Signature: _____

License Number: _____ Area of Specialty: _____

Provider Address:
_____

City: _____State: _____Zip Code: _____

Telephone Number: _____ Fax Number: _____