

Authorization For Release Of Confidential Information

Office of Student Disability Services
Fax: (918) 458-2340

Northeastern State University
600 N. Grand Avenue
Phone: (918) 444-2120

To: _____
(Licensed or Certified Professional or Agency)

Street Address: _____

City, State, Zip: _____

Telephone: _____

(Print Your Name)

(Street Address)

(City, State, Zip Code)

(Home Telephone)

_____ is attempting to provide proof of disability to
(Social Security Number)

Northeastern State University in order to obtain educational accommodation. The release form is intended to give permission to release documentation pertaining to his/her disabling condition to the Student Disability Services Office at Northeastern State University. Whenever relevant the information provided should contain the following:

1. The most current records that provide the basis for specific diagnosis (es) or classification within the DSM-IV or ICD.
2. The testing dates or time frame which the examination, assessment, and /or evaluation was completed.
3. A description of the nature and extent of the disability (ies) and identification of the functional limitations and when possible the educational needs of the client.
4. Identification of any prescribed medications that have a cognitive and/or physical effect, as well as a description of symptoms.

Signature of Person Applying for Services

Date

Please keep this original for your records.