

To ensure the provision of reasonable and appropriate accommodations, students requesting services must provide current documentation of their disability. This documentation should provide information regarding the onset and severity of the disability, as well as describe how it interferes with educational achievement. In order to establish that an individual is covered under ADA and Section 504 of the Rehabilitation Act of 1973, documentation must demonstrate that the individual has a disability and it substantially limits some major life activities, including learning. If accommodations, academic adjustments and/or auxiliary aids are being requested, the documentation provided must support the request. Appropriate accommodations will be determined based on the specific information submitted in the documentation.

- Please sign this Release of Information Form and submit it with the required Psychological Disability Documentation Form completed by a qualified professional evaluator to:

**Northwood Technical College**  
**Ashland Campus**  
2100 Beaser Avenue  
Ashland, WI 54806  
Phone: (715) 682-4591  
Fax: (715) 682-8040

**Northwood Technical College**  
**Superior Campus**  
600 N. 21st Street  
Superior, WI 54880  
Phone: (715) 394-6677  
Fax: (715) 394-3771

**Northwood Technical College**  
**Rice Lake Campus**  
1900 College Avenue  
Rice Lake, WI 54868  
Phone: (715) 234-7082  
Fax: (715) 234-5172

**Northwood Technical College**  
**New Richmond Campus**  
1019 South Knowles Ave.  
New Richmond, WI 54017  
Phone: (715) 246-6561  
Fax: (715) 246 2777

I, \_\_\_\_\_ hereby authorize the release of requested information to the Disability Services Office at Northwood Technical College for the purpose of determining my eligibility for educational accommodations. Authorization remains in effect for one (1) year from the date of my signature.

I understand that I have the right to refuse to sign this authorization form and it may be revoked in writing at any time prior to the disclosure of this information.

**Re-disclosure Notice:** The information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by HIPAA.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth:

**This form must be completed and signed by a licensed physician, psychiatrist or clinical psychologist.**

Student Name \_\_\_\_\_ DOB \_\_\_\_\_

DSM IV  
Category

Axis I. \_\_\_\_\_  
Code \_\_\_\_\_

Axis II. \_\_\_\_\_  
Code \_\_\_\_\_

Axis III. \_\_\_\_\_

Axis IV. \_\_\_\_\_

Axis V. \_\_\_\_\_

Date of diagnosis

Date of last visit

How often do you regularly meet with this student?

I. Does this condition interfere with any of the following major life activities?

- walking     hearing     seeing     working     learning     manual tasks

II. Describe the functional limitations and/or behavioral manifestations (e.g., easily distracted, poor concentration, difficulty focusing for extended period of time, difficulty formulating and executing plan of action, difficulty overcoming unexpected obstacles, panic in unfamiliar surroundings and situations, exam taking, attendance, memory, information processing, full credit load, etc.) and recommendations you have for an academic setting. (These recommendations should be based on diagnostic information and results.)

Behavioral Manifestation:

Recommendations:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

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III. List any medication(s) prescribed and side effects being experienced:

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IV. Describe information you have concerning this student's academic strengths and weaknesses that might be helpful in making decisions as to the appropriateness of any requests for accommodations:

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Name of Licensed Physician: \_\_\_\_\_  
(please print)

License # \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_  
(please print)

Signature \_\_\_\_\_ Date \_\_\_\_\_