ANTELOPE VALLEY COLLEGE
OSD RELEASE OF INFORMATION
Office for Students with Disabilities

Name/Address of College	**Name/Address of Treating Physician/Verifying Professional**
Attn. Office for Students with Disabilities	
Antelope Valley College	
3041 West Avenue K	
Lancaster, CA 93536	

Name of Student:_____*__**Student ID#:900-**_____
Birthdate:_____ **Telephone #**:_____

OSD Release of Information:

I, _____, authorize the release of information from _____regarding my
(Name of Student) *(Name of Treating Physician or Verifying Professional)*
disability(ies) _____ to _Antelope Valley College_____. All information will be kept confidential
(Identify disability(ies)) *(Name of College/Attn. OSD Director)*
and maintained as a part of my records with the California Community College Chancellor's Office, Disabled Student Programs and Services(DSP&S). I authorize the release of information to include one or more of the following records identified below:

- ☐ Diagnosis of disability.
- ☐ Psychological testing and evaluation results.
- ☐ Vocational Rehabilitation Plan.
- ☐ Individual Education Plan (IEP)
- ☐ 504 Plan
- ☐ Detailed results of assessment, psychological, or medical testing that led to the diagnosis.
- ☐ Other:

A photocopy of this document is as valid as the original.

I further give permission for OSD staff to discuss my educational situation with other professionals who have a legitimate need to know.

This authorization shall remain in effect until revoked in writing by the undersigned.

Student Signature: 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 the Office for Students with Disabilities Program. 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). 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.

ANTELOPE VALLEY COLLEGE
OSD DISABILITY VERIFICATION

Office for Students with Disabilities

THIS SECTION MUST BE COMPLETED BY THE STUDENT

Name:_____*__**Student ID#: 900-**_____

Address:_____

Birthdate:_____**TELEPHONE #**:_____

In order to receive disability-related services at Antelope Valley College a verification of disability may be required. I request that the professional designated below complete this form.

Name of Licensed or Certified Professional:_____

Address:_____

TELEPHONE #:_____**FAX #**:_____

THIS SECTION MUST BE COMPLETED BY THE LICENSED OR CERTIFIED PROFESSIONAL

Please provide the following information, in full in order to help determine educational accommodations to support this student:

1. Diagnosis:_____
2. DSM- 5 Code and Severity (if applicable)_____
3. Please describe how this condition substantially limits major life activities:_____
   _____
   _____
4. Condition is: o stable o prone to exacerbation
5. Duration of Disability: o Permanent/Chronic o Temporary (estimated duration of disability)_____

Please return this form to:

o College – Antelope Valley College, Attn: Office for Students with Disabilities, 3041 W. Avenue K, Lancaster, CA 93536

I understand that the information provided by the verifying professional will become part of the student record, and may be released to the student upon their written request.	
Verifying Professional Signature	Date
If the above information is completed by someone other than the professional who made the diagnosis, please provide the name and address of the person who made the diagnosis in the space provided below.	

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