Counseling and Disability Services
One Cumberland Square
Lebanon, TN 37087
(615) 547-1397

Authorization for Exchange of Information

Name: ____________________________________ Social Security Number: ______________________

Date of Birth: _______________________________

By signing below, I hereby authorize the staff members of the Cumberland University Office of Disability services to exchange the following information with:

Name: ____

Address____

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_____Date of Assessment and Diagnosis
_____Current Impact of Disability and Limitations on Academic Performance
_____Treatments and Medications in Current Use
_____Estimated Effectiveness of Treatments or Medications in Lessening the Impact of Disability
_____Expected Duration, Stability, or Progression of the Condition
_____Clinical Summary of Procedures and Instruments Used to Make the Diagnosis
_____Diagnostic Interview and/or Testing Results
_____Specific Recommended Academic Accommodations With Rationale for Each Recommendation
_____Complete DSM-IV-TR Diagnosis in Multi-axial Format, Current Symptoms
_____ Any additional information needed to coordinate Disability Services
_____Other:_______________________

Limitations, if any:

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I understand that this information will be exchanged to provide quality care and to better coordinate services. I understand that I may revoke this consent at any time by notifying the parties involved in writing. I sign this form voluntarily and understand that this authorization will automatically expire one year from this date. If I choose not to sign this authorization, I understand that my refusal to sign this form will result in the information NOT being exchanged and that this may have an impact on the ability to receive special accommodations under ADA at Cumberland University.

Signature: ____ Date: _________