PIERCE COLLEGE

Disabled Student Program

Consent for Release of Information

Student's Name: _____ Birth Date:_____

Student ID #: ☐☐☐☐☐☐☐☐☐

In accordance with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies, I hereby request verification of my psychological disability on this form. ALL INFORMATION WILL BE KEPT CONFIDENTIAL.

Student Signature_____ Date:_____

THIS SECTION TO BE COMPLETED BY
LICENSED PSYCHOLOGIST OR PSYCHIATRIST

Print Doctor's Name : _____

License #: _____

Doctor's Address :_____

Doctor's Phone # _____

DSM III-R Diagnosis (Axis I or Axis II) : _____

Educational Limitations Related to Diagnosis :_____

Doctor's Signature: _____

PLEASE SEND OR FAX **JUST THIS FORM** TO:

PIERCE COLLEGE DISABLED STUDENTS PROGRAM
6201 Winnetka Avenue
Woodland Hills, CA 91371
818 719-6430 (office)