

Program: \_\_\_\_\_  
Site: \_\_\_\_\_  
Date Out: \_\_\_\_\_  
Date In: \_\_\_\_\_

**Foothill College**  
ADAPTIVE LEARNING DIVISION (ALD)  
12345 El Monte Road  
Los Altos Hills, CA 94022  
Tel.No: (650)949-7332 Fax: (650)917-1064

Status: \_\_\_\_\_  
Qtr: \_\_\_\_\_

**RELEASE OF INFORMATION**

Student's Name: \_\_\_\_\_ SSN: \_\_\_\_\_  
Date Of Birth: \_\_\_\_\_ Medical Record No: \_\_\_\_\_

I hereby authorize the release of information from:

**Name of Treating Physician:** \_\_\_\_\_  
**(or Verifying Professional):** \_\_\_\_\_  
**Address:** \_\_\_\_\_  
**Phone:** \_\_\_\_\_

to Foothill College, Adaptive Learning Division / Disability Resource Center regarding my disability and/or functional limitation. All information will be kept confidential and maintained as part of my records with the California Community College Adaptive Learning Division and Disability Resource Center. I authorize the release of information to include one or more of the following records:

- Diagnosis signed by an appropriate medical practitioner or psychologist
  - Psychological testing and evaluation results
  - Vocational Rehabilitation Plan
  - Individual Education Plan (I.E.P.)
  - Detailed results of assessment, psychological or medical testing that led to the diagnosis
  - Other: \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

\_\_\_\_\_  
**Student's Signature** \_\_\_\_\_  
**Date**

**A photocopy of this document is as valid as the original.**  
**This authorization shall remain in effect until revoked in writing by the student.**