



University of Phoenix®

STUDENT RELEASE OF INFORMATION

The following University of Phoenix Student/Applicant has self-disclosed a condition protected under the Americans with Disabilities Act (ADA). Further medical verification or clarification may be requested or is required for the purpose of determining reasonable accommodations. Medical information will be treated confidentially and stored separately from the student's academic record.

This section may be completed by Student/Applicant or the Diagnosing Professional:

Diagnosing Professional Name: _____

Title: _____

Credentials: _____

Address: _____

(City)

(State)

(Zip Code)

(Area Code & Phone number & Extension)

I hereby authorize the above Diagnosing Professional to release all pertinent disability-related information as noted under the Americans with Disabilities Act (ADA) to University of Phoenix in order to determine reasonable accommodations in the academic environment.

Student Printed Name

IRN

Student Signature

Date

PLEASE RETURN TO: Campus disability services advisor

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

E-mail Address: _____