Disability Support Services
Request & Release Form

PLEASE USE BLACK OR BLUE INK TO COMPLETE THIS FORM

Name:________________________________ Semester: ☐ Fall ☐ Spring ☐ Summer

Student ID: ___________________________ Year: ____________________

Address: _______________________ City: ___________ State: _____ Zip: _______

Home Phone: _________________________ Cell Phone: ____________________

E-mail: ______________________________ Date of Birth: ___________________

Emergency Contact: ______________________________ Relationship: ____________________

Phone: _______________________________ Secondary: ____________________

DISABILITY INFORMATION

Categories-check all that apply:

☐ ADD/ADHD ☐ Auditory ☐ Chronic Illness ☐ Mobility
☐ Neurological ☐ Physical ☐ Psychological ☐ Seizures
☐ Specific Learning Disability ☐ Visual ☐ Service Animal

Specific Diagnosis(es): ____

Specific Accommodations Requested: ____

____

Type of Documentation Submitted: _________________ Date Submitted: ____________

VERIFICATION INFORMATION:

I give permission to Disability Support Services to contact my parents and/or legal guardians and my diagnosing healthcare professional in their attempt to verify my eligibility for academic accommodations. I understand that this permission extends to verification process only. I also understand that arranging services will necessitate sharing with my instructors information regarding my disability as it relates to my academic welfare. I give my permission for DSS personnel to contact my instructors regarding my academic progress, as needed.

____ _______________

Student Signature Date

Office Use Only

☐ NEW ☐ SAME AS PRIOR ☐ CHANGED ☐ DOCUMENTATION PROVIDED

NOTES: ____

RELEASE OF RECORDS INFORMATION

I hereby authorize Southwest Mississippi Community College's Disability Support Services to communicate with the following: ***(Please check)***

- ☐ Parents
  List exclusions: ____

- ☐ SMCC Faculty/Staff, On Campus Services (i.e. Campus Police, etc.)
  List exclusions: ____

- ☐ Off Campus Services (i.e. Professionals, Schools, Vocational Rehab, etc.)
  List exclusions: ____

Communication as denoted above may include obtaining and/or releasing student's historical and/or current information regarding assessment, diagnosis, needs, recommendations, treatment, prior services, academic records, performance, or information that may relate to accommodating student's needs on SMCC's campus. This consent form will be valid until revoked by student. A photocopy of the original consent form shall be as valid as the original consent form.

Signature____**Date** ________________

Witnessed by____________________________________ **Date** ________________

This form requires a second signature from another individual. Please have this individual sign on the line after "Witnessed by."

DISCLOSURE INFORMATION:
By completing and signing this intake application, you are voluntarily disclosing a disorder and requesting accommodations. You understand that disclosure of your disorder at this time does not necessarily confirm your eligibility status for services or accommodations. You also understand that the length of the verification process will depend upon the appropriateness of the documentation that you have submitted. In addition, you understand that all information submitted to this office is to be completely confidential and used only for this institution's commitment and obligation to students with disabilities.

By signing below, you confirm that you have read and understand this document.

____
Student Signature **Date**

____
DSS Staff Signature **Date**

Date Application Received ________________