VICTOR VALLEY COLLEGE

American with Disabilities Act

Consent for Release of Medical and Psychological Information Form

Employee Name: _____ I.D.#: _____

Other Name Used:_____

Address :_____Phone:_____

Date of Birth:_____

I,_____, the undersigned, consent to, and request all appropriate persons, and/or agencies or institutions, to release information regarding myself to the Human Resources and ADA office Victor Valley College for use to determine eligibility for work place adjustments. All information will be kept confidential and maintained as a part of my records with the Human Resource office at Victor Valley College.

I authorize the release of information to include one or more of the following records:

- Initials_____Learning Disability Assessment or report with raw scores
- Initials_____ Psycho-educational report
- Initials_____ Visual acuity/visual pathology
- Initials_____ General medical and /or specialist exam/report
- Initials_____ Psychiatric evaluation/report

I further give permission for the ADA Compliance officer to discuss my accommodation concerns with other professionals who have legitimate educational need to know.

This authorization shall remain in effect until revoked in writing by the undersigned.

Employee Signature: _____Date:_____

A PHOTOCOPY OF THIS RELASE IS AS VALID AS THE ORIGINAL

FOR 90 DAYS.