

Western Oregon University
Office of Disability Services
Academic Programs and Support Center 405
Monmouth, Oregon 97361
Phone: 503-838-8250 V/TTY
Fax: 503-838-8721

Release of Medical Information

C o n f i d e n t i a l I n f o r m a t i o n F o r P r o f e s s i o n a l U s e O n l y
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Student Name: _____ Social Security: _____

Date of Birth: _____ Phone: _____

Signature: _____ Date: _____

I authorize release of the following medical information to the Disability Services at Western Oregon University, from my physician:

_____ Physician's Name

_____ Address _____ City _____ State _____ Zip Code

_____ Phone _____ V/TTY _____ Fax

The student named above has applied for services through the Office of Disability Services at Western Oregon University. In order to qualify for academic assistance, the student must present medical documentation. Please provide the following information to our office at your earliest convenience. It is possible that the Office of Disability Services will contact you for additional information as needed.

1. Specific Diagnosis: _____
2. Prognosis: _____ Permanent _____ Temporary _____ Specify length _____
3. What are the functional effects/limitations of this diagnosis for this person specifically as it relates to being in an academic environment?

4. Does the disability limit mobility? (circle) Yes No Indicate: Pain Fatigue
How? Explain:

Difficulty Walking _____ Speed _____ Distance _____
Stairs _____ Extended Standing _____

5. Does this disability affect academic pursuits? (circle) Yes No
How? Explain:

Visual _____
Hearing _____
Hand/arm mobility _____
Attention _____
Other _____

Physician's Signature: _____ Date: _____