

**Authorization to Release Medical Information (Voluntary) for Academic Adjustment
Purposes based on Pregnancy or Related Conditions**

Student completes this document.

Student Full Name: _____

College ID: _____

I am releasing medical information from my healthcare provider as described below for the sole purpose of assisting the College or appropriate staff in evaluating and implementing appropriate academic adjustments, reasonable modifications, or supportive measures related to my educational program.

It is my decision or my healthcare provider's responsibility to determine any academic or campus risks and to identify any limitations or restrictions that may affect my academic performance. I acknowledge that this information will be used by the College to assist in determining appropriate accommodations, adjustments or modifications. I further acknowledge that, without this information, the College may be unable to make a final determination regarding my request for an accommodation, adjustment, or modification.

Information from a healthcare provider is voluntary and released at the student's discretion.

My healthcare provider has provided the following type(s) of information (check all that apply):

_____ Functional limitations

_____ Recommendations for accommodations, adjustments, or modifications.

_____ List of limited or restricted activities

_____ Other: _____

This information will be maintained as confidential and the College will limit disclosure to individuals necessary for evaluating any related health limitation or condition and whether a reasonable modification can be achieved.

Student Signature: _____ **Date:** _____

Directions to Instructional Department: If the Title IX Coordinator is not present, provide a copy of this completed and signed request form to the student and the Title IX Coordinator.