Healthcare Provider Statement

This form must accompany the Disclosure of Disabling Condition and Request for Academic Adjustment form

STUDENT COMPLETES THIS SECTION

FIRST NAME	M.I.	LAST NAME

DATE OF BIRTH	EMAIL ADDRESS	PHONE NUMBER

MAILING ADDRESS (Include Apt # if applicable)

Street (Include Apt # if applicable) City State Zipcode

NAME OF HEALTH CARE PROVIDER	HEALTH CARE PROVIDER'S PHONE

I hereby authorize the above-named health care provider to complete this form and disclose to Summit Academy OIC (SAOIC) and its authorized representatives the following information related to my health care: the diagnosis(es) of relevant conditions, treatment plan(s), and my ability to be successful in my academic program, recommendations, history, reports and correspondence.

I understand that it may be necessary for SAOIC representatives to share this information for purposes related to accommodation of a disability. I authorize the SAOIC to share this information among appropriate staff and authorized representatives to the extent necessary to determine whether accommodation is necessary and to administer the accommodation process.

Once disclosed, the law does not always require the recipient of my information to maintain the confidentiality of my health care information. I understand that I have the following rights: a) to inspect or receive a copy of my protected health information, b) to receive a copy of this signed authorization, and c) to refuse to sign this authorization. I understand that information obtained under this release is a confidential medical record and is maintained separate from my student academic file. I understand that I may revoke this consent, in writing, at any time except to the extent that action has already been taken based on the original authorization. I also understand that the abovenamed health care provider will not condition treatment or payment based on receipt of this signed authorization.

I hereby authorize my healthcare provider to discuss directly with SAOIC's representatives any medical/mental health information relevant to my accommodation request.

By signing this page, I acknowledge that I have read and agree to the terms described above. (NOTE TO STUDENT: If you do not provide authorization for your healthcare provider to discuss the medical/mental health information relevant to your accommodation request, processing of your accommodation request may be delayed.)

Student's Signature & Date: _____

Return this and all relevant documentation to the Director of Student Services.

HEALTHCARE PROVIDER COMPLETES THIS SECTION

Your patient is requesting an accommodation at Summit Academy OIC. The information you provide is critical to our ability to determine the appropriate services and/or accommodations, if any, for this student. Please be thorough in your evaluation as you complete the information requested below as it will help us assist your patient. **Your timely completion of this form is essential to our ability to respond to your patient's accommodation request. If you fax the completed form, please send the original hard copy by mail to the address at the bottom of the page.**

EVALUATION SUMMARY

Pertinent Diagnosis(es)	Describe Related Functional Limitation(s)	Temporary or Permanent?	Onset; duration of treatment for this condition

RECOMMENDED REASONABLE ACCOMMODATIONS (PART ONE)

Based on your patient's disability, what accommodations would contribute to his/her success as a post-secondary student? Check all that apply:

☐ Extra time on homework assignments
☐ Extra time on in-class assignments/projects
☐ Extra time on exams
☐ Separate testing room
☐ Removing or reducing distractions in classroom
☐ Additional training time for learning new skills
☐ Permitted to take extra breaks
☐ Having an assigned seat in the classroom
☐ I have additional recommendations to make (please complete part two below)

RECOMMENDED REASONABLE ACCOMMODATIONS (PART TWO)

If you have additional recommendations to make, please provide them here (use additional paper if necessary). If it is more convenient to provide additional information/recommendations on a separate sheet of paper, please ensure that you do so **on letterhead** and provide a **signature and contact information for the qualified professional providing the information:**

SIGNATURE OF HEALTH CARE PROVIDER

I attest that the information on this document is true and accurate.

Health Care Provider Name (please print or type)		**Provider's Specialty**	
Street Address	**City**	**State**	**ZIP**
_____ **Signature of Health Care Provider & Date**	**Phone**		**Fax**

Return to: *Summit Academy, Attn: Dir. Of Student Services, 935 Olson Memorial Hwy, Minneapolis, MN 55405 or fax to 612.377.0156*