PALMER College of Chiropractic

TEMPORARY MODIFICATION REQUEST FORM

Part I. Instructions to student: Please complete Part I below. This form will be forwarded to your health care provider for completion of Part II.

AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

I, _____, _____
[Name of Patient] [Date of Birth]

authorize _____ to release my Protected Health Information to:

Palmer College of Chiropractic

Attn: ☐ Academic Affairs; Office of the Dean or Associate Dean ☐ Student Academic Support Centers

☐ Main Campus	☐ Florida Campus	☐ West Campus
1000 Brady Street	4777 City Center Parkway	90 E. Tasman Drive
Davenport IA, 52803	Port Orange, FL 32129	San Jose, CA 95134

To release and/or discuss the following information: ☐ Complete Records ☐ X-Ray Report ☐ X-Rays ☐ Other_____

I specifically authorize that any sensitive information regarding (CHECK ALL THAT APPLY): ☐ HIV/AIDS, ☐ Substance Abuse (alcoholism or drug abuse), or ☐ Mental Health be released to the above referenced recipients.

I understand that if the authorized recipient is not a healthcare provider, health plan, or clearinghouse required to comply with federal privacy standards, the information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and my health information may be re-disclosed by the recipient without obtaining any further authorization.

This authorization is granted for the following purpose: to identify any needed temporary modifications to the academic program for a specified length of time.

PATIENT'S RIGHTS RELATING TO THIS AUTHORIZATON:

I understand that I must be provided with a copy of this form if I choose to sign it. I understand that I am under no obligation to sign this form. I understand that I may revoke this Authorization by notifying Palmer College of Chiropractic in writing of my revocation. To obtain information on how to revoke my Authorization or to receive a copy of my revocation, I am to contact the Privacy Officer at (563) 884-5701. I am aware that my revocation will not be effective as to uses and/or disclosures of my health information that the person(s) and or organization(s) listed above have already made in reliance on this Authorization.

EXPIRATION DATE: This authorization expires ☐ 6 months; ☐ one year from today's date; ☐ upon the following specified event: _____.

I have had an opportunity to review and understand the content of this Authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes

Name (Signature):	Date:
Name (Print):	
Current Address:	

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Part II. Instructions to Health Care Provider. Your patient has notified the College of their orthopedic condition, scheduled surgery, injury and/or illness and their need for assistance. Your input and additional information is needed to coordinate any necessary modifications to their academic program.

Patient Name:
Condition resulting in the need for the classroom modification:

Description of the specific functional limitations or restrictions the diagnosis presents for the student, particularly with regard to functioning in a rigorous academic environment, studying, participating in chiropractic technique simulations, participating in physical exam and neuromuscular exam partner exercises, and taking written and practical exams.

What classroom or testing modifications will your client require in order to minimize exacerbations of their condition and/or the residual functional limitations listed above?

Check all that apply:

☐ Scribe ☐ Supplemental course notes ☐ Audio recording of lectures ☐ Standing desk ☐ Book prop

☐ Adjustable lighting for written exams and quizzes ☐ Quiet testing environment

☐ Modified written and/or practical exam schedule ☐ Time and ½ for written exams

☐ Time and ½ for practical exams ☐ Additional time to navigate the campus between classes

☐ Modified classroom seating: at front, near exit, other: _____ (please circle all that apply)

☐ Soft seating in class/in testing center (please circle all that apply)

☐ Student is excused from participating in simulated examination and treatment of the following areas during in-class activities (please select all that apply):

☐ Cervical spine ☐ Thoracic spine ☐ Lumbar spine ☐ Face/jaw ☐ Upper extremity R/L
☐ Lower extremity R/L ☐ Other: _____
☐ Palpation – static ☐ Palpation – motion ☐ Prone set-ups ☐ Supine set-ups ☐ Seated set-ups
☐ Side-lying set-ups ☐ Assessment with instrumentation (Nervoscope, Tytron) ☐ In-class adjusting

☐ Ortho/Neuro exams: _____ (please list)

☐ Physical exams: _____ (please list)

☐ Other: (please describe)

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Anticipated length of time that the above temporary modifications will be necessary:
Based on my personal evaluation of the patient's condition, the above information is accurate and complete. _____ _____ Health Care Provider Signature Date _____ _____ Printed Name Specialty _____ _____ Phone _____ _____ _____ Address Fax

This signed, completed form and any additional supporting documentation including inventories and outcomes assessment forms may faxed to:

Davenport, Iowa Campus:

□ Dr. Alex Margrave, Phone: (563) 884-5257, Fax: (563) 884-5244, alex.margrave@palmer.edu

□ Dr. Michelle Drover, Phone: (563) 884-5106, Fax: (563) 884-5532, michelle.drover@palmer.edu

□ Dr. Michael Tunning, Phone: (563) 884-5865, Fax: (563) 884-5532, michael.tunning@palmer.edu

Port Orange, Florida Campus:

□ Mr. Victor Hidalgo, Phone: (386) 763-2780, Fax: (386) 763-2635, victor.hidalgo@palmer.edu

□ Dr. William Sherrier, Phone: (386)763-2714, Fax: (386) 763-2757, william.sherrier@palmer.edu

□ Dr. Alena Coleman, Phone: (386) 763-2674, Fax: (386), 763-2757, alena.coleman@palmer.edu

San Jose, California Campus:

□ Dr. Greg Snow, Phone: (408) 944-6008, Fax: (408) 944-6111, snow_g@palmer.edu

□ Dr. Brian Nook, Phone: (408) 944-6055, Fax: (408) 944-6111, brian.nook@palmer.edu

□ Mr. Michael Crump, Phone: (408) 944-6122, Fax: (408) 944-6032, michael.crump@palmer.edu