



PAGE 1 (TO BE COMPLETED BY THE STUDENT): AUTHORIZATION TO EXCHANGE CONFIDENTIAL INFORMATION

Form with fields for Patient Name (Last, First, MI), SeattleU ID#, Address (Street, City, State, Zip), and Phone (Area code, Number), and a field for Date of Birth (DOB).

I, _____ authorize _____
(Student/Patient/Legally Authorized Representative) Medical Provider Name & Organization

TO DISCLOSE THE FOLLOWING HEALTH INFORMATION

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my initials in the applicable space next to the type of information:

(Please Initial)

HIV/AIDS Information

Mental Health Information

Drug/alcohol diagnosis, treatment, or referral information

TO: (receiving party): Anton Ward-Zanotto, Ph.D., Dean of Students

This form may be submitted by the student or their medical provider to:

Email: deanofstudents@seattleu.edu

Fax: 206-296-6063

Mail: 901 12th Ave., Student Center 140, Seattle, WA 98122

In Person: Student Center 140

PURPOSE OF DISCLOSURE: Petition for Withdrawal for Medical Reasons

This authorization may be revoked at any time except to the extent already relied upon, and unless earlier revoked by written notice filed with the above named disclosing party/institution. This authorization shall expire upon termination of my professional services with above named disclosing party/institution or one year from the date of signing, whichever comes first.

I hereby release the above named disclosing party/institution and its staff from any and all legal liability that may arise from release of information. I understand that once the information is used or disclosed pursuant to this Authorization, the information may be subject to redisclosure and no longer protected.

Patient signature: _____ Date: _____



PAGE 2 (TO BE COMPLETED BY THE STUDENT'S HEALTHCARE PROVIDER)

STUDENT/PATIENT NAME

Medical Record #

The above patient/student has requested a Withdrawal for Medical Reasons from their classes at Seattle University. Before we can grant the request, we need the following information from a healthcare provider. Seattle University only grants a request for a Withdrawal for Medical Reasons in the event of an unforeseen, uncontrollable, and unavoidable physical or psychological illness or an injury that impeded the student's ability to attend, complete, or participate in their courses. Seattle University does not approve requests related to minor illnesses or injuries.

Medical Provider Name: Credential(s): MD/DO NP/PA PHD/PSYD LMHC/LICSW
Hospital/Practice Name: City/State:
Phone Number: Email Address:

Attach additional information or documentation as needed.

1. What is the nature of the patient's/student's illness or injury? Please include: diagnosis/es, current treatment plan, and when the treatment plan should be reviewed for progress.

Approximate Date that Illness/Injury Began:

- Check All That Apply: Temporary Illness/Injury. Date or Expected Date of Symptom Resolution
Ongoing or Chronic Medical Issue (No Known End Date or Unable to Determine)
Patient/Student Hospitalized for ___ Days
Patient/Student Has Started Treatment
Patient/Student Has Completed Treatment

2. How did/does the patient's/student's illness or injury specifically prevent them from preparing for, attending, and/or participating in their classes? If the illness or injury impacted only some of the student's classes, please explain why.

3. Did the patient/student report information that may indicate a present risk of harm to self or others? If yes, please describe.

4. How long will the illness/injury prevent the student from preparing for, attending, and/or participating in classes?

5. Please share any additional information that may be relevant for the purposes of considering the patient/student's request for a Withdrawal for Medical Reasons. If needed, additional documentation may be attached.