



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 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 was approved for a Withdrawal for Medical Reasons from their classes at Seattle University in the current or previous term. To ensure that the illness or injury that resulted in the Withdrawal for Medical Reasons has been treated and a satisfactory level of recovery attained, the university has required the student to provide updated healthcare information and an assessment of their ability to handle the demands of being a student.

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 patient's/student's diagnosis/es and treatment plan? What progress has been made? If treatment has not been completed, when should the treatment plan be reviewed?

Approximate Date that Treatment 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. What is your professional opinion regarding the patient's/student's current ability to handle the intellectual, physical, social, and/or personal demands of:

- (a) Being a full-time student at Seattle University.
(b) Living safely and independently in a residence hall (if applicable), providing appropriate self-care, and utilizing available support and treatment resources.
(c) Participating in other university programs and activities. For example: student employment, athletics, recreation activities, and/or study abroad?

3. Recommendations for special accommodations, additional medical evaluations, or consultations with specialists.