SEATTLE UNIVERSITY

Release Authorization to Disclose Confidential Information

Patient Name:_____ Former Name:_____
Last First MI
Address:_____
Street City State Zip

Phone: ( )_____ DOB_____

I, _____ authorize_____
(Patient/Legally Authorized Representative) (Name of Disclosing Party/Institution)

_____Phone: ( ) _____
(Address)
_____ Fax #: ( ) _____
(City, State, Zip)

TO DISCLOSE THE FOLLOWING HEALTH INFORMATION (Please describe the information to be disclosed):_____
_____
_____

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:

_____HIV/AIDS Information

_____Mental Health Information

_____Drug/alcohol diagnosis, treatment or referral information

TO: (receiving party) _____
(Name of Person / Organizational Affiliation)
_____Phone: ( )_____
(Address)
_____ Fax #: ( )_____
(City, State, Zip)

PURPOSE OF DISCLOSURE: _____
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:_____

SEATTLE UNIVERSITY

Health Care Statement
in Support of Student's Request
for Hardship Withdrawal

STUDENT'S NAME _____

The above student has requested a hardship withdrawal from his or her classes at Seattle University. Before we can grant the request, we need the following information from a health care provider.

Seattle University only grants a request for a hardship withdrawal in exceptional circumstances; for example, when there is an incapacitating illness and/or injury to the student that prevents completing all classes. Our institution does not grant hardship withdrawals for minor or short-term illnesses or injuries.

Your name: _____ Your title: _____

Your address:

_____
Number & Street Apt/Suite Number

_____
City State Zip

Phone number where you can be reached: (_____)_____
Area Code

Attach additional information or documentation as needed.

1. What is the nature of the student's illness or injury?

   _____

   _____

2. To what extent has the student's illness or injury been incapacitating?

   Date that incapacity began: _____

   Date that incapacity ended or is anticipated to end _____

3. Was the student hospitalized? Yes ☐ No ☐

   What was the duration of hospitalization? _____

4. How does the student's illness, injury, or hardship prevent preparing for and/or attending classes? Be specific.

   _____

   _____

5. If continuing, how long will these conditions prevent the student from attending classes?

   _____

   _____

▶ Your signature _____ **Date** _____