Academic Appeal

RELEASE OF PROTECTED HEALTH INFORMATION

PERMISSION IS HEREBY GIVEN TO:

_____

(Name and Address of Organization or Individual Releasing Information)

TO RELEASE INFORMATION TO:

RMATION TO:

Student Name: _____Date of Birth: _____

Guidelines for Medical Documentation

If your academic appeal includes consideration of a medical condition, the information requested below should be completed as fully as possible by the licensed healthcare provider(s) providing treatment.

Description of the medical condition and its functional impact on the student's academic performance:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Specific dates of the condition and treatment period that may have affected the student's academic performance:

Date of onset:

_____

Date of treatment(s):

_____
_____
_____

An assessment of the student's current ability to return to full or part-time college study:

_____
_____
_____
_____
_____
_____
_____

Name, title/professional credentials of healthcare provider:

_____

Signature_____ Date: _____

Please include seal of authenticity.

Address: _____
_____
_____

Phone: (_____) _____ - _____

In order to release this information, the student must sign the "Release of Confidential Information"