AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

From Treating Professional
To the University of Richmond

_____ _____
(Name of Student/Client) (UR ID #)

* *

I HEREBY AUTHORIZE: _____
(Name of Treating Health Professional)

To share confidential and relevant health information with the University by providing a treatment summary and any necessary recommendations for the purpose of determining my readiness to return to Richmond, assisting with coordination of follow-up treatment upon readmission, and developing an appropriate behavioral contract (if needed).

* *

I understand that the information supplied by my treating professional will be shared with the professionals in the Counseling and Psychological Services Office (CAPS) and the Student Health Center. Information supplied by my treating professional may also be shared with members of the Readmission Committee, if necessary to determine my readiness to return to Richmond or to develop an appropriate set of conditions for return (if needed).

I understand that my treating professional may also have an authorization form they need me to sign. If so, I agree to fully cooperate in signing that form.

This release will be invalid one year after the date of authorization cited below.

I understand that I have the right to revoke this authorization in writing to the appropriate Dean's Office at any time, unless the University or my treating professional, have already acted upon it.

_____ _____ _____
Printed Name Student Signature Date of Signature