University of Colorado
Denver | Anschutz Medical Campus

Authorization to Release / Obtain / Exchange Confidential Information

I, _____, _____/_____/_____
Student's name *date of birth*

Request and authorize:

_____
Treating Professional Name or Agency *License Number*

_____
Address *City* *State* *Zip*

_____ _____
Provider's Phone *Provider's Email*

To release information to / exchange information with:

University of Colorado Denver Office of Case Management; Phone: (303) 315-7307, Fax: (877) 556-7704

The following confidential professional information, including personal, psychological, psychiatric, and/or medical records and opinions, resulting from my contacts with the treating professional:

____Dates of Treatment and Attendance
____Verification of Letter of Support
____General Nature of Medical Condition and impact on coursework
____Other: _____

This release will remain in effect until _____. (Note: This release is **not** valid without a date of expiration).

I am aware that I have no obligation to disclose the requested information and that I may revoke this consent at any time by notifying the Office of Case Management. I may request to review and copy the information disclosed. I understand and agree that a reproduction of this authorization will be valid and accepted with the same authority as the original. I have been advised that by not providing consent, the Office of Case Management will be limited in its ability to assist me.

_____ _____
Student signature *date*