University of Colorado
Denver | Anschutz Medical Campus

Re-enrollment: Authorization to Release / Obtain / Exchange Confidential Information

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

Request and authorize:

_____
Treating Professional's Name and 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
____Recommendation concerning the student's ability to remain in the university environment
____Re-Enrollment Questionnaire
____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 (in writing) 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*

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Re-enrollment Questionnaire

Instructions: This section is to be completed by the student's treating physician or treating licensed mental health provider. Please respond completely to each of the questions below. Fax the completed form and statement directly to the Office of Case Management, Fax Number 877-556-7704.

Please Respond to ALL Questions

Full Name of Student:_____

Are you a/n: _____ M.D. _____Licensed Mental Health Provider

Specialty:_____

License Number:_____

Did you provide treatment for the above named Student? _____ Yes _____No

Diagnoses/Condition(s) being treated: _____

_____

_____

Are you continuing to provide treatment? _____ Yes _____No

If you are no longer providing treatment, was treatment terminated with your approval? ____ Yes ____No

Do you believe the Student will be able to function appropriately at the University and should be able to return as a student? _____ Yes _____No

If so, when is the earliest date the Student should be able to return to classes? _____

_____ _____
Signature of Treating Professional Date

_____ _____
Name of Treating Professional (please print or type) Phone Number

_____
Address of Treating Professional

Please note that the Office of Case Management will call and verify that this questionnaire was completed by the treating professional stated above. The student's re enrollment request will not be accepted for review unless the re-enrollment release of information and questionnaire are completed and verified.

Section to be completed by the Office of Case Management

Date Received:_____
Verified:_____
Hold Removed:_____
Physician's License Number Confirmed: □Yes □No