# Provider Form for Medical Leave
# Emory University

The Division of Campus Life collaborates with an individual student's school of enrollment to ensure that students in need of time away for medical reasons are provided with resources, coordinated care, and assistance throughout the medical leave process. Information shared with and between campus partners (e.g. Counseling & Psychological Services (CAPS), Student Health Services (SHS), Student Case Management & Intervention Services (SCMIS), Department of Accessibility Services (DAS), and the designated academic dean(s) of the school) will only be used to determine a student's eligibility for a leave and level of support/care needed. Completion of this authorization will give the above offices permission to share, disclose, receive and exchange my student health records and protected health information relevant to your leave with your treatment providers.

Part I: TO BE COMPLETED BY THE STUDENT

Student Full Name: _____ DOB: _____
Preferred Name:_____

Student ID Number: _____
Emory email address_____ Alternate email: _____
Student Phone Number:_____
Term for which you are requesting an MLOA: Term ____ Year____

I authorize my treating health care provider(s), CAPS, SHS, SCMIS, DAS, and their respective designees to share, disclose, receive and exchange my student health records and protected health information as necessary to evaluate my request for medical leave. This may include appointment verification, summaries of treatment, progress and recommendations, concerns regarding my wellbeing, diagnosis, treatment plan, medications, and care recommendations. This authorization is for coordination of care, case management, consultation, and evaluation of my medical leave request.

The information disclosed may include privileged psychiatric or psychological records, information related to the treatment of physical or mental health treatment, substance use treatment, and testing or treatment for communicable or infectious disease, including HIV/AIDS, hepatitis, tuberculosis, and sexually transmitted diseases. I waive any privilege applicable to such information for the purposes of authorization and release Emory University, its facilities, and their officers, trustees, agents and employees from any claims or liability arising from disclosure of the health information authorized herein.

I understand I may revoke this authorization in writing at any time, except to the extent Emory University or my provider has already acted in reliance on it. This is authorization expires (specify date or event that relates to the purpose or use of this disclosure): _____

Student's Signature:_____Date:_____
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