Provider Treatment Assessment and Recommendations for Return to Emory University from Medical Leave of Absence

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)) will only be used to determine a student's eligibility for return and the level of support/care needed upon return. Completion of this authorization will give the above offices permission to communicate and disclose student health records and information relevant to your return with your treatment providers.

Part I: TO BE COMPLETED BY THE STUDENT

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

Student ID Number: _____
Student Phone Number: _____
Emory email address :_____ Alternate email address: _____
Requested term for return from leave: Fall 20___ Spring 20____ Summer 20___(please fill in 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 a return from a medical leave of absence. This may include appointment verification, treatment summaries, progress notes and recommendations, concerns regarding my wellbeing, diagnoses, treatment plans, medications, and care recommendations. This authorization is for purposes of care coordination, case management, consultation, and evaluation of my medical leave or return 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 diseases, 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: _____