



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

OFFICE OF CASE MANAGEMENT

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