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# Medical Withdrawal Healthcare Provider Report

**This form is used in addition to the Semester Withdrawal form. If the information submitted by the healthcare provider is insufficient to decide on the medical withdrawal, a representative from the Office of Vice President & Dean of Students may contact the student's healthcare provider for more information.**

## Student Instructions

1. Complete the Semester Withdrawal form.
2. Complete and return this form directly to the address below via mail, fax, or email.

## Student Information (please print)

Name: _____
Last First Pronouns Goucher ID

Mailing Address: _____
Street City State Zip Code

Phone: _____ Email address: _____

## Licensed Healthcare Provider Information

Name: _____
Last First

Title: _____ Clinic/Hospital Name: _____

Mailing Address: _____
Street City State Zip Code

Phone: _____ Email address: _____

## Student Statement and Signature

I, the above-named student, have applied for a medical withdrawal from Goucher College for the following medical reason(s):

_____

_____

**I, with this document, authorize the release of medical and/or mental health information between the above provider and any of the following Goucher College administrators from these offices: Vice President & Dean of Students, Associate Provost for Undergraduate Studies, Student Health Center, Student Counseling Center, and Residential Life. In addition, these administrators may redisclose the information from the provider as well as other pertinent information concerning my physical or mental health to the following individuals:**

Parent/Guardian: _____ Phone: _____

Other: _____ Phone: _____

Student's Signature: _____ Date: _____

**Return form:** Office of Vice President & Dean of Students
Dorsey 203, 1021 Dulaney Valley Road
Baltimore, MD 21204
Email: care@goucher.edu
Fax: 410-337-6494

Student Name: _____
Student ID #: _____
Grad. Year: _____
DOB: _____

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STUDENT COUNSELING CENTER
1021 Dulaney Valley Road
Towson, MD 21204
P: 410-337-6481
F: 410-337-6005

# AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS AND INFORMATION

**I, the undersigned student or legal representative, hereby authorize** Student Counseling Center / Office of Vice President & Dean of Students
**□ to disclose □ to receive ■ to exchange**
**the following information from my records in verbal, electronic and/or written form:**

- ☐ Psychiatric evaluation from Date:_____
- ☐ Mental Health Records from Date:_____ to Date:_____
- ☐ History and Physical exam performed on Date:_____ Time: _____
- ☐ Lab reports**, x-ray reports, and other test results from Date:_____ to Date:_____
- ☐ Verification of treatment
- ☐ Other:_____

**I am aware that the records released may contain information related to sexually transmitted disease, HIV-status, alcohol/drug use, or mental health. I, specifically, PROHIBIT the release of the following information (SPECIFY):**

**_____INITIAL HERE:_____**

**Purpose of disclosure of information (check all that apply):**

- ☐ At client's request
- ☐ Continuing care
- ☐ Verification of services provided
- ☐ Other:_____

**Person/institution to whom information is to be disclosed:**

- ☐ Self
- ☐ Goucher College Student Counseling Staff:_____
- ☐ Goucher College Administration/Faculty/Staff: _____
- ☐ Non-Goucher Recipient: _____

Address:_____

Phone/Fax: _____

**Expiration Date of Authorization (may not exceed one year): _____**

**Student Signature _____ Date: _____**

Signature of Legal Representative (if applicable):_____ Describe authority to act for the student:_____

You may revoke this authorization at any time, by writing to: Director, Goucher College Counseling Center. The revocation will become effective on the date received by Director. The recipient of information covered in this release may not make any further disclosure of the information without specific consent of the student or his/her legal representative or as otherwise provided by law.