Physical Medical Withdrawal Reenrollment Provider Report

Part A – To Be Completed and Signed by Individual

I _____ am requesting **readmission for** .
Print name term/year
My Medical Withdrawal was during the _____ semester of _____. From _____ to .
(Fall/Spring/Summer) (YEAR) (MM/YY) (MM/YY)

I have supplied the provider with all information about my health history, medical symptoms, or other related to my ability to function as a student.

I voluntarily consent to the bidirectional release of information between the provider named below and the University of North Florida Dean of Students Office & Medical Withdrawal Committee (DOSMW). This release is for the purpose of making decisions about my request for reenrollment and coordinating care, and includes **entire medical record.** Paper or electronic copies of this authorization shall be sufficient authorization for the release of records. I release University of North Florida, my therapist and their supervisor(s) from any liability arising from the release, miscommunication, or failure to release information, provided the release is done substantially in accordance with the law. I understand that I need not sign this consent form in order to receive services at this facility. The DOSMW makes no claims or guarantees about the handling of information by the parties above once released and agrees not to hold University of North Florida, DOSMW, or its staff liable for any consequences that result from such disclosure or non-disclosure. Individuals receiving the information may be governed by different or less strict laws/guidelines regarding the release of information than the counseling center staff. I understand that I may revoke these permissions at any time in writing, except to the extent that the providers have already acted in reliance on it. Absent such prior withdrawal this consent will expire in one year from last contact. Please speak with DOS staff and other relevant parties before signing if you have any questions. Reenrollment is not guaranteed. ***By signing this release form, I acknowledge that I have thoroughly read, understood and voluntarily granted all aforementioned permissions.***

Signature of Individual: _____ Date_____

PART B – Licensed Health Provider | *Please return by mail or fax. More info may be attached but* ***a letter <u>will not</u> substitute for completion of this form.***

Provider's Name: Provider Phone:
Provider Fax: _____
Licensed as _____

Patient's Name: Patient Date of Birth _____/_____ /

1) Medical Withdrawal Diagnosis: _____
2) Has the condition resolved:
3) Please list any future limitations the student may experience: _____
_____
4) Is this a chronic condition: _____
5) If Chronic, what treatment or medication will assist the student prevent a relapse?
_____

Clinician Signature _____Date_____

ONCE COMPLETED, PLEASE FAX THIS DOCUMENT TO (904) 620-3922