

**Campus Support and Intervention  
University of Southern California  
Los Angeles, CA 90089-3102  
(213) 740-0411 phone**

**Applicant's Name:** \_\_\_\_\_

**Date of Birth:** \_\_\_\_\_

**Student ID No.:** \_\_\_\_\_

**Dates of leave of absence:** \_\_\_\_\_

## **RELEASE OF INFORMATION FOR ACADEMIC READINESS EVALUATION**

I, \_\_\_\_\_, hereby authorize the treatment provider or team named below to exchange information pertaining to my evaluation and/or treatment for the purpose of assessing my academic functioning level, safety, and readiness to return from leave.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I understand that authorization shall remain valid from the date of my signature below and for 9 months thereafter ending on: \_\_\_\_\_

I have been informed that I may revoke this authorization by written communication to the provider named at any time. I certify that this form has been fully explained to me and that I understand its contents.

\_\_\_\_\_  
**Signature of Client**

\_\_\_\_\_  
**Date of Authorization**

\_\_\_\_\_  
**Signature of Witness**

\_\_\_\_\_  
**Date**

**Applicant's Name:** \_\_\_\_\_

**Please have your provider fill out this section. If you are seeing more than one health care provider, please copy this form, have each provider complete it, and then email the completed forms as PDF email attachments to your Health Leave Coordinator.**

**Name:** \_\_\_\_\_ **Credentials:** \_\_\_\_\_

**Address:** \_\_\_\_\_

\_\_\_\_\_

**Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**1. What services or care are you providing to the student?**

**2. What was the duration of the treatment?** \_\_\_\_\_

**What was the frequency of the visits?** \_\_\_\_\_

**Date of last visit:** \_\_\_\_\_

**3. Please indicate others involved in this student's care (name, address, phone numbers):**

**Family:** \_\_\_\_\_

**Other Professionals:** \_\_\_\_\_

**Hospitals:** \_\_\_\_\_

**4. How stable is the student's condition? Do you have concerns about their return to a highly rigorous university environment for the coming semester?**

**5. What recommendations for further care have you made to the student now?**

**6. Can you identify any specific precipitants that could put the student at risk?**

**7. What additional support might benefit this student in their continued recovery (e.g. special living situations, altered intensity of academic stresses, structured activities, etc.)?**

**8. Will you continue to play any role in this student's care upon their return to school?**

**9. Please note other important observations or comments:**

**If you require more space to answer the above questions, you may include additional documentation as well as the completed form.**

**Thank you for your assistance.**

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**Provider Signature**

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**Date**