



UNIVERSITY OF SOUTHERN CALIFORNIA

HEALTH LEAVE OF ABSENCE FORM

(For any health-related leave, including medical, psychological, or combined reasons.)

SECTION A – AUTHORIZATION FOR THE MUTUAL RELEASE OF PROTECTED HEALTH AND EDUCATION INFORMATION

Student Name: _____

USC ID #: _____

Date of Birth: ____ / ____ / ____

Semesters of Leave: _____

Telephone: _____ **Email:** _____

Address: _____

1. Purpose of This Authorization

To facilitate coordination related to my Health Leave of Absence (HLOA) and potential return to enrollment, I authorize a mutual exchange of information between the University of Southern California (USC) and my healthcare provider(s) for the limited purpose of assessing, managing, and supporting my health leave and readiness to return to academic participation.

This authorization permits:

- My healthcare provider(s) to release information protected under **FERPA** (if the provider is with USC Student Health), **HIPAA**, and **CMIA** to USC; and
- USC to disclose information protected from my education records under **FERPA** to my healthcare provider(s).

2. Parties Authorized to Exchange Information

University Office:

Office of Campus Support & Intervention

Phone 213-740-0411

Email vhla@usc.edu

Healthcare Providers: Any licensed or credentialed healthcare provider, clinician, or facility with whom I am currently in care, or enter into care after the date of this authorization, for purposes related to my health leave and readiness to return (e.g., physicians, psychiatrists, psychologists, therapists, surgeons, rehabilitation clinicians, hospitals, or allied-health professionals).

3. Type and Scope of Information Authorized for Release

All information reasonably necessary to evaluate, implement, or monitor my health leave and readiness to return.

4. Duration and Revocation

This authorization remains in effect **until the conclusion of my Health Leave of Absence process, unless earlier revoked in writing.**

I may revoke at any time by written notice to USC’s Office of Campus Support & Intervention and any treating provider(s). Revocation will not affect disclosures made before notice was received.

5. Understanding, Acknowledgment, and Release

I understand this release may include sensitive medical, mental-health, or substance-use information. I understand that signing is voluntary but required to process my HLOA and return. I may request a copy of this signed authorization.

I hereby release USC, its employees, trustees, officers, and agents, both individually and collectively, from any and all liability for damage of whatever kind, which may at any time result to the undersigned, my heirs, family and/or associates because of USC’s compliance (or attempt at compliance) with this authorization and consent to disclose FERPA-protected information and/or documents.

6. Signatures

Student (or Legal Representative):

Signature: _____ Date: _____

Print Name: _____

If Legal Representative, describe authority: _____

FOR OFFICE USE ONLY

Date Received ____/____/____ Processed By: _____

PART I – PROVIDER RECOMMENDATIONS FOR HEALTH LEAVE OF ABSENCE

Purpose

To document the health-related basis for recommending a Health Leave of Absence and to outline the treatment, recovery, or stabilization plan expected during the leave.

1. Reason for Recommending Health Leave of Absence

Describe the medical and/or psychological condition(s) or functional impairments warranting the leave, including any risk or safety factors (e.g., suicidal ideation or attempts, hospitalizations, self-harm behaviors, substance use, psychosis, major surgery or injury, chronic-illness flare-ups, neurological event, or other acute health crises).

Risk Assessment:

Factor	Active (past 3 mo)	Inactive	Stable	Not Assessed	Comments / Mitigation
Chronic Illness Flare / Decompensation					
Homicidal Ideation					
Major Medical Complication (e.g., post-surgical, neurologic event)					
Mobility or Functional Impairment					
Psychosis / Disordered Perception					
Self-Harm Behaviors					
Sleep or Energy Disturbance					
Substance Use / Abuse					
Suicide Attempts					

Factor	Active (past 3 mo)	Inactive	Stable	Not Assessed	Comments / Mitigation
Suicidal Ideation					
Other (specify):					

2. Recommended Plan of Care

Indicate recommended course of care, including frequency and duration, and any step-down phases (e.g., inpatient → outpatient → follow-up).

<i>Modality / Service</i>	<i>Frequency / Duration</i>
Group Therapy	
Individual Psychotherapy	
Inpatient Stabilization	
Intensive Outpatient or Partial Hospitalization	
Nutrition / Metabolic Counseling	
Medical or Surgical Follow-Up	
Primary / Specialty Medical Care	
Psychiatry / Medication Management	
Rehabilitation / Physical / Occupational Therapy	
Other:	

3. Other Recommendations During Leave

List other recommended activities (e.g., physical recovery, structured routine, limited work hours). Outside coursework requires approval from the Health Leave Team and academic advisor.

4. Anticipated Challenges and Support Recommendations

Identify anticipated challenges upon return (e.g., cognitive load, mobility, fatigue, emotional readiness) and supports recommended to assist transition (continued treatment, accommodations, community resources, etc.).

5. Summary for Return – Goals to Be Revisited in Part II

Summarize primary goals or indicators of readiness to be met before return (e.g., medication stability, symptom control, rehabilitation milestones, consistent therapy participation).

Student Signature _____ Date _____

Provider Signature _____ Date _____

6. Provider Information

Name _____ License # _____ State _____

Facility / Program _____

Address _____

Phone _____ Email _____

Signature _____ Date _____

3. Treatment Timeline

Date of First Appointment	Total Sessions Seen	Last Date of Treatment	Next Scheduled Appointment

Did the student discontinue care against medical advice? Yes No

Was attendance consistent? Yes No

Will treatment continue after the student returns to school? Yes No

4. Diagnoses and Current Conditions

List diagnoses made or confirmed and describe current status (medical and/or psychological):

5. Prior Treatment History

Had you treated the student before the leave? Yes No If yes, for what condition(s) and when?

6. Other Professionals or Programs Involved

Family/Supportive Others: _____

Other Providers / Specialists: _____

Hospitals / Programs: _____

7. Risk and Safety Assessment

Factor	Active (past 3 mo)	Inactive	Stable	Not Assessed	Comments / Mitigation
Chronic Illness Flare / Decompensation					
Homicidal Ideation					
Major Medical Complication (e.g., post-surgical, neurologic event)					
Mobility or Functional Impairment					
Psychosis / Disordered Perception					
Self-Harm Behaviors					
Sleep or Energy Disturbance					
Substance Use / Abuse					
Suicide Attempts					
Suicidal Ideation					
Other (specify):					

If any risk is active or stable, describe its nature, severity, and supports needed:

8 Current Functioning and Readiness to Return

Comment on current medical and/or psychological stability, functioning, and capacity to resume academic and campus life.

Do you have concerns about readiness to return? Yes No If yes, explain and note recommended supports.

9 Identified Stressors or Potential Precipitants

Describe stressors that could increase risk of relapse or health decline and preventive supports recommended.

10. Ongoing Support and Accommodation Recommendations

List supports or accommodations to promote continued stability (e.g., continued therapy or rehab, reduced course load, mobility assistance). Note: accommodations are determined by OSAS.

11 Continuity of Care Plan

Will you continue to treat the student after return? Yes No If no, describe referrals or handoff plan.

12 Provider Certification

I have reviewed the student's original Part I form and confirm that this information accurately reflects care received, progress made, and current readiness to return.

Signature _____ Date _____ License # _____ State _____
Printed Name _____ Credentials _____
Address _____ Phone _____
Email _____

13 Student Signature

I have reviewed this information with my provider and affirm its accuracy.

Signature _____ Date _____

Submission Instructions

Submit the complete packet (Authorization + Part I + Part II) to your Health Leave Coordinator.
Email PDF forms to vhla@usc.edu or call 213-740-0411 for questions.