Student Health Service
Division of Student Life
East Carolina University
Greenville, NC 27858-4353
252-328-6841 office · **252-328-4007** fax
www.ecu.edu

MEDICAL WITHDRAWAL REQUEST
AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____ _____, hereby authorize the release of identified information to be:
Name Banner ID #
(Check One)
_____**released from** Student Health Service to the indicated second party.
_____**released to** Student Health Service from the indicated second party.
__x__**exchanged between** Student Health Service and the indicated second party.
_____**I** also authorize the information to be transmitted by Fax. Student's initials:_____
___x_**I** also authorize the information to be transmitted by E-MAIL. Student's initials:_____

Second party: ___CCSD ___Academic Advising ___Faculty/Staff/Administration
___Campus Living ___Disability Support Service ___Office of Student Rights & Responsibilities

Other: Name: _____

Address:_____
_____

Phone: _____

Information to be released or exchanged:
___All Treatment Records ___Intake Report _x_Class Attendance and Assignment Completion
___Summary of Treatment ___Case Notes ___Psychological Testing
___Diagnosis & Dates of Treatment ___Other, Specify:_____

This information is to be released for the following purpose:___Evaluation of Medical Drop/Withdrawal Request

I authorize release of information for the following dates:___All dates of contact
Other (specify):_____

I understand the nature/need of the information to be released. The authorization given on the indicated information is primarily for the parties stated above. This request will remain valid for one year unless I choose to revoke this authorization by submitting a written statement. A photocopy of this form is as valid as an original. I hereby state that I am competent and fully understand the terms of this release.

_____ _____
Student Signature Date

_____ _____
Witness Signature Date

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