## Boston College - University Counseling Services Authorization to Release/Exchange Information Pertaining to Return from Medical Leave of Absence

In order to evaluate a student's readiness to return from a Medical Leave of Absence we must be able to communicate with that student's treatment provider. To better facilitate a successful re-engagement at Boston College, we must be able to communicate recommendations to relevant but limited offices on campus. This authorization identifies those individuals, and provides your consent to communicate in facilitation of this process.

I, \_\_\_\_\_\_, authorize Boston College University Counseling Services located in Gasson 001, 140 Commonwealth Avenue, Chestnut Hill, MA 02467 (phone: 617-552-3310) to exchange information with (Please check all three boxes as appropriate):

<ul> <li>Boston College Office of Student Outreach and Support</li> <li>Boston College Academic Dean:</li></ul>		
[]       Treatment Provider while on Leave of Absence	Name:	
	Phone:	
Student Phone:		
Student Address:		
<ul> <li>The purpose of this disclosure is for:</li> <li>[ ] Treatment Planning</li> <li>[ ] Leave of Absence/Readmission process</li> <li>[ ] Other (specify)</li></ul>		
This consent is effective on	and expires on	
	g, at any time by sending such written notification to BC University when received by University Counseling Service and will not affect zation.	
	ollege may not require me to sign this authorization as a condition logical services are provided to me for the purpose of creating	

health information for a third party.

I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient of your information and may no longer be protected by law.

Name:	_ Date of Birth:	BC ID #:
Signature:	C	Date: