



**Authorization to Release / Obtain / Exchange Confidential Information**

I, \_\_\_\_\_, \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
*Student's name* *date of birth*

**Request and authorize:**

\_\_\_\_\_  
*Treating Professional Name or Agency* *License Number*

\_\_\_\_\_  
*Address* *City* *State* *Zip*

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

**To release information to / exchange information with:**

University of Colorado Denver Office of Case Management; Phone: (303) 315-7307, Fax: (877) 556-7704

The following confidential professional information, including personal, psychological, psychiatric, and/or medical records and opinions, resulting from my contacts with the treating professional:

- \_\_\_\_ Dates of Treatment and Attendance
- \_\_\_\_ Verification of Letter of Support
- \_\_\_\_ General Nature of Medical Condition and impact on coursework
- \_\_\_\_ Other: \_\_\_\_\_

This release will remain in effect until \_\_\_\_\_. (Note: This release is **not** valid without a date of expiration).

I am aware that I have no obligation to disclose the requested information and that I may revoke this consent at any time by notifying the Office of Case Management. I may request to review and copy the information disclosed. I understand and agree that a reproduction of this authorization will be valid and accepted with the same authority as the original. I have been advised that by not providing consent, the Office of Case Management will be limited in its ability to assist me.

\_\_\_\_\_  
*Student signature*

\_\_\_\_\_  
*date*

**OFFICE OF CASE MANAGEMENT**