# Academic Appeal

RELEASE OF PROTECTED HEALTH INFORMATION

**PERMISSION IS HEREBY GIVEN TO:**

_____

*(Name and Address of Organization or Individual Releasing Information)*

**TO RELEASE INFORMATION TO:**

Attn: Director of the Wellness Center
St. John Fisher College
3690 East Avenue
Rochester, NY 14618

Voice: 585-385-8280
Fax: 585-385-8299

**REGARDING:** _____

*(Name of Student)* *(Date of Birth)*

**FOR THE PURPOSE OF** considering the student's academic appeal, this information will be shared, as appropriate, by the Director of the Wellness Center with the Associate Registrar and the Committee on Academic Standing in evaluating the student's appeal to the Committee.

**NATURE OF INFORMATION TO BE DISCLOSED:**

(1) Description of the medical condition and its functional impact on the student's academic performance, (2) specific dates of the condition and treatment period that may have affected the student's academic performance, and (3) an assessment of the student's current ability to return to full or part-time college study.

**By signing this form, the Student acknowledges the following:**
*I understand that my consent to release/obtain information expires at the conclusion of this academic appeal. I understand I may withdraw this consent in writing at any time by writing to:*

_____

*(Name and Address of Provider)*

*I understand that the confidentiality of my health information may not be protected by federal laws or regulations once it is disclosed by my health care provider to a third party. I understand that my health care provider may not require me to sign this document as a condition of continuing to provide me with health care or any other benefit to which I am otherwise entitled.*

_____ _____

*Student's Signature/Date* *(Parent/Legal Guardian Name) If under 18 yrs of age*

_____ _____

*Parent/Legal Guardian Signature* *(Parent/Legal Guardian Address)*

**Student Name: _____Date of Birth: _____**

**Guidelines for Medical Documentation**

If your academic appeal includes consideration of a medical condition, the information requested below should be completed as fully as possible by the licensed healthcare provider(s) providing treatment.

- ☐ Description of the medical condition and its functional impact on the student's academic performance:

_____
_____
_____
_____
_____
_____
_____
_____
_____

- ☐ Specific dates of the condition and treatment period that may have affected the student's academic performance:

Date of onset:
_____
Date of treatment(s):
_____
_____
_____

- ☐ An assessment of the student's current ability to return to full or part-time college study:

_____
_____
_____
_____
_____
_____
_____

Name, title/professional credentials of healthcare provider:
_____

Signature_____ Date: _____
*Please include seal of authenticity.*

Address: _____
_____
_____

Phone: (_____) _____ - _____

***In order to release this information, the student must sign the "Release of Confidential Information"***