

INDIANA UNIVERSITY

College of Arts and Sciences

Request for Information and Waiver Form from the Office of Undergraduate Academic Affairs

(Student: provide this form to your clinician)

To: Medical and mental health professionals

From: The College of Arts and Sciences, Indiana University

Dear clinician,

The Academic Retention Committee of the College of Arts and Sciences at Indiana University has asked one of our students, who is also a client of yours, to provide documentation to help us reach a decision regarding his/her current academic standing and eligibility to enroll for future semesters. This request is coming to you because the student attributed past significant academic difficulties, at least in part, to a health and/or wellness issue. We ask for this information to verify that the student has received a clinical diagnosis and to establish that the student has pursued a course of treatment. This information will inform our decision about whether or not to allow the student to register for classes in an upcoming term.

To help you prepare a letter, we would like you to know something about our role and how the information you provide to us can help. We realize that health professionals must abide by the Health Insurance Portability and Accountability Act (HIPAA), and we ourselves are strictly limited in what we can share with outside parties about a student's academic records by the Family Education Rights and Privacy Act (FERPA). We therefore have not contacted you directly, but rather we have instructed the student to give this form to you personally so that you can discuss exactly what information the student is willing for you to share with us.

***We welcome any advice you can share, but we are particularly interested in the following questions:

- For what condition or illness did you treat this individual?
- In your professional opinion, how much would this issue have impaired this student's ability to complete academic work prior to the beginning of treatment?
- When did you begin treating the patient and what plans are in place to continue treatment when the student returns to school?
- Does this treatment plan include an ongoing regimen of prescription medications? If so, can you describe the potential risks of a sudden cessation in such a course of treatment?
- In your professional opinion, is it currently in the student's best interests to return to full or part-time studies?
- If the student is cleared for registration, do you have any specific recommendations regarding the student's course of studies, workload and scheduling, etc. ?

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PERMISSION TO RELEASE MEDICAL INFORMATION PERTINENT TO MY ACADEMIC STANDING IN THE COLLEGE OF ARTS AND SCIENCES AT INDIANA UNIVERSITY

I give my permission for my healthcare professional

(print name and role—i.e. doctor/counselor/nurse/ assistant, etc.)

to give information about my current state of health, ongoing treatment and ability to resume full or part-time studies to the College's Academic Retention Committee (which determines a student's eligibility to enroll).

This permission is considered to be in effect until rescinded by me in writing.

If there is any specific type of information that may not be released to the Academic Retention Committee, please note it here:

Student's signature: _____ Date: _____

Student's name (please print): _____

Student IU Identification Number: _____

CLINICIAN—PLEASE RETAIN THIS FORM FOR YOUR RECORDS

Revised Aug 2011