Request for Voluntary Medical Leave of Absence

This form is to be completed by students requesting a Voluntary Medical Leave of Absence (MLOA) from Drake University and, at the student's discretion, may be provided to any one of the following individuals:

a. The Associate Dean of the College in which the student has most recently enrolled ("Associate Dean")
b. The Drake University Counseling Center ("Counseling Center")
c. The Drake University Student Health Center ("Health Center")

Student Statement and Request:

1. I am experiencing a health issue that I believe is significantly impacting my academic and or university life and I am therefore requesting a MLOA.
2. I am submitting this request to (check one):
   __The Associate Dean of the College in which I have most recently enrolled
   __The Drake University Counseling Center ("Counseling Center")
   __The Drake University Student Health Center ("Health Center")
3. I will provide my licensed health care provider with a signed patient's waiver provided to me by the University authorizing him or her to discuss my request for a Voluntary Medical Leave of Absence with the with the above individuals and to provide any relevant medical records, facts, opinions and recommendations pertaining to my request.
4. If I am submitting this request to my Associate Dean, I authorize my Associate Dean to discuss and share the information provided herein and any information received from my licensed health care provider on a need-to-know basis with the Counseling Center or Health Center (my "Primary Health Liaison"). I further understand my Primary Health Liaison may request a meeting with me follow up directly with my licensed health care provider.
5. If I am submitting this request to the Drake University Counseling Center or the Drake University Student Health Center, I authorize them to discuss and share the information provided herein and any information received from my licensed health care provider on a need-to-know basis with my Associate Dean.
6. I understand my Associate Dean is ultimately responsible for granting or denying all student applications and requests for leaves of absence, including MOLAs, within my School or College and I will be informed by the Associate Dean whether my request for a MLOA had been granted or denied.

_____
(Student Signature)

_____
Student's Printed Name

_____
Date

Authorization for Release of Medical/Psychological Information to Drake University
(pertaining to voluntary medical leave of absence)

I am currently enrolled as a student at Drake University and have requested a voluntary medical leave of absence from the University because I believe I am experiencing a health issue that is significantly impacting my academic and or university life. In order to consider my request, the University may require relevant medical/psychological records, facts, opinions and recommendations from you. Therefore, I voluntarily authorize the direct _____ _____ _____ _____ _____ _____ to release any relevant medical records, facts, opinions and recommendations that pertaining to my request for this leave of absence to:

(Check one of the following)

☐ Associate Dean
Drake University
College of _____
_____

_____

☐ Drake University Counseling Center
2970 University Ave
Des Moines, IA 50311
(515) 216-5100

☐ Student Health Center
2970 University Ave
Des Moines, IA 50311
(515) 216-5100

I understand this disclosure may include any or all of the following information:

1. Oral and /or written disclosure of counselor/therapist/health care provider notes, and/or records as a result of any medical exams, evaluations, and therapy/counseling sessions.
2. The results of any medical and psychological tests performed.
3. Any progress notes.
4. Any history obtained
5. Other _____

I understand the information to be released may include information in the following categories unless I specifically indicate that should not be released by checking below:

(INITIAL ANY CATEGORY NOT TO BE RELEASED)
Substance Abuse _ Mental Health _ HIV-Related Info _

This authorization is effective for months, but no longer than one year from the date of my signature below. I understand I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon it, by giving written notice to the name and address I have checked above.

I certify that any person(s) who may furnish any information disclosed pursuant to this Authorization for Release of Medical/Psychological Information to Drake ("Authorization") shall not be held accountable for releasing or disclosing such information, and I hereby release said person(s) from any and all liability for damage of whatever kind which may at any time result to me, my heirs, and my family and my associates because of compliance with this Authorization.

I further release Drake University from any and all liability for damage of whatever kind which may at result to me, my heirs, my family and my associates because of information it receives pursuant to this Authorization.

Signature of Patient/Client or Legal Representative _____ Date: _____

Relationship to Patient/Client if signed by Legal Representative: _____

Prohibition of Redisclosure: This form does not authorize redisclosure of information beyond the limits of this consent. Where information has been disclosed from records protected by federal law for mental health records, federal requirements (42 C.F.R. Part 2) and state requirements (Iowa Code Ch. 228) prohibit further disclosure without the specific consent of the patient/client, or as otherwise permitted by such law and/or regulations. A general authorization for the release of information is NOT sufficient for these purposes. Civil and/or criminal penalties may attach for unauthorized disclosure of alcohol/drug abuse or mental health information.