Request for a Voluntary Health Withdrawal

University of Nevada, Las Vegas

UNLV students may apply for a Voluntary Health Withdrawal (VHW) if they experience medical or psychological conditions that significantly impair their ability to function successfully and safely in their role as a student. Students must submit required documentation from a licensed health/mental health provider to the Voluntary Health Withdrawal Committee (VHWC). At no additional charge, students may receive a medical or psychological evaluation from Student Wellness which includes the Student Health Center (702-895-3370), Student Counseling and Psycdcdcantng ænang .en0 Tc 0 Tbdi

Health Care Provider Evaluation Summary for Health Withdrawal *(page 2 of 2)*

Treatment history:

___

___

___

Describe the reason(s) why the student's condition warrants a health withdrawal:

___

___

___

___

___

Treatment recommendations during the period of the health withdrawal:

___

___

___

___

___

___

Clinician's Signature

___

Clinician's Printed Name (REQUIRED)

___

Clinician's License Type, Number, State (REQUIRED)

Mailing Address:

___

___

___

UNLV Voluntary Health Withdrawal Committee

UNLV Voluntary Health Withdrawal Committee
4505 Maryland Parkway / Box 452005, Las Vegas, Nevada 89154-3020
(702) 895-0136 | FAX (702) 895-4316

AUTHORIZATION FOR DISCLOSURE OF PATIENT HEALTH INFORMATION

(For purposes other than treatment, payment or health care operations)

Name: ____ **DOB:**__________________ **NSHE #:**_____________________

Phone No. to contact you:_________________________________

I HEREBY AUTHORIZE INFORMATION TO BE RELEASED:

FROM:	**TO:**
Name/Agency: ____	**Name/Agency:**____
Address: ____	**Address:**____
Phone: ____	**Phone:**____
Tax: ____	**Tax:**____

- **Allow mutual disclosure between agencies listed above**

PURPOSE FOR RELEASE: ____

INFORMATION TO BE RELEASED (Include Date of Service):

- Last pap report
- Office/Consult Notes
- X-ray reports (specify): ____
- Lab reports (specify): ____
- Immunizations (specify): ____
- Other (specify): ____

SPECIFIC AUTHORIZATION: The undersigned acknowledges, agrees, and understands that any health information released MAY INCLUDE information that is related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), behavioral or mental health services, and/or treatment for alcohol and/or substance abuse. My signature below authorizes release of all such information.

This authorization is effective immediately and is subject to revocation in writing at any time, except to the extent that action has already been taken in reliance thereon. Otherwise, this authorization **expires one year from date of signature.**

The confidentiality of medical, psychiatric and substance abuse information is protected by State and Federal Statutes, Rules and Regulations including Nevada Revised Statutes and Title 42 of the Code of Federal Regulations. These Statutes, Rules and Regulations require that the individual give informed consent prior to the release of