



## Medical Documentation Form

Undergraduate Academic Services  
(843) 953-567  
FAX (843) 953-5544  
E-Mail: [Undergrad@CofC.edu](mailto:Undergrad@CofC.edu)

Client/Patient \_\_\_\_\_ SSN: \_\_\_\_\_  
Last First MI

Date of Birth \_\_\_\_\_

I request the release of medical information to the Office of Undergraduate Academic Services.

Signature \_\_\_\_\_

Illness (DSM-IV Diagnosis, if applicable) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of Diagnosis: \_\_\_\_\_

Duration, Intensity and Frequency of Symptoms: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Justification for Late Course Withdrawal: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Treatment Provided/Dates of Treatment: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature and Credentials of Health Professional

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Name and Address (print or type, please)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone Number \_\_\_\_\_