

**UVA Department of Student Health  
General Medicine  
Student Reenrollment**

**Consent for Communication with Academic Dean  
Pertaining to Medical Clearance for Reenrollment**

I, \_\_\_\_\_ hereby provide permission for  
Name of Student

UVa Student Health General Medicine to communicate with my academic dean for the purpose of providing recommendations pertaining to my medical withdrawal and/or subsequent medical clearance for reenrollment.

Name of Academic Dean: \_\_\_\_\_

I understand that communication with my dean will only apply to the medical withdrawal and medical clearance issues and will not cover any post-enrollment treatment-related information.

Student Signature: \_\_\_\_\_

Student ID#: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_

This authorization of release pertains only to the above-specified information and to the above-specified parties. I also understand that I may revoke this authorization at any time in writing except to the extent that Student Health General Medicine has already taken actions in reliance on it, and that the authorization will remain valid until revoked or upon expiration of one year from the date of this signed release.

**Please fax the completed form to: (434) 243-9669  
Attention: Nursing Supervisor**