CARTHAGE
COLLEGE

HEALTH AND COUNSELING CENTER
AUTHORIZATION TO RELEASE OUT OF CLASS NOTICE

Student Name:_____ **DOB:**_____ **ID#:**_____

Absence Dates:_____ **Are you an Athlete:** _____

I hereby authorize and request: Carthage College Health and Counseling Center
2001 Alford Park Drive
Kenosha, WI 53140
262.551.5710

To Release the following information: Out of Class Notice for Medical reasons
To: Dean of Students staff (Nick Winkler & Liz Snider)
Athletics - only if an Athlete

Advisor's Name:_____Email:_____

Professor's Name:_____Email:_____

Professor's Name:_____Email:_____

Professor's Name:_____Email:_____

Professor's Name:_____Email:_____

Professor's Name:_____Email:_____

Campus Employment Supervisor's Name:_____ Email:_____

Coach's Name :_____Email:_____

Reason for request: Out of class notice for medical reasons

I understand that my records are protected by Federal and State Confidentiality regulations and cannot be disclosed without my consent. I understand that I have the right in inspect and receive a copy of the disclosed information.
I understand that this consent will be in effect for 90 days unless otherwise noted:_____
I understand that I may revoke this authorization at any time except to the extent that action has already been taken.

Student Signature:_____ **Date:**_____

HCC Staff Signature:_____ **Date:**_____

Notice will be sent upon return of completed form and medical documentation stating the dates student is excused and a return to class date.