



**Physician/Therapist Fills Out the Section Below – Please Print Clearly**

*The provider filling out this form **cannot be a relative of the student**. Please do not submit a prescription in lieu of filling out this form. Please return a copy of the signed Authorization to Release Information with this form.*

To determine eligibility for special housing, St. Mary's College of Maryland requires current and comprehensive documentation of the student's condition from a licensed health care provider or clinical professional who is familiar with the history and functional limitations of the student's condition(s). Your assistance is greatly appreciated. Please complete all items in detail. If the space provided is not adequate, please continue on the back of the page. The physician/therapist may also attach a report providing additional related information. Due to limited availability of air conditioning units, **only students with asthma or moderate/severe persistent allergies** will be considered for window air conditioners. Students with seasonal allergies are encouraged to bring their own HEPA filter air purifiers for personal use in their rooms.

Student's Name: \_\_\_\_\_

1. How long have you known this patient? \_\_\_\_\_
2. State the symptoms and actual condition/diagnosis and explain in lay terms the medical/psychological rationale for the above request: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- a. How long has the patient had this condition? \_\_\_\_\_
- b. What is the severity of the condition? \_\_\_\_\_
- c. In the last year, how many times have you treated this student for this condition?  
\_\_\_\_\_
- d. How long is this condition likely to persist? \_\_\_\_\_

3. Have you seen this student for any other related conditions pertinent to this request? If yes, how recently and what was the treatment? \_\_\_\_\_

\_\_\_\_\_

4. List all medications, including OTC and non-medication treatment that the student is currently using to manage this condition. Include dosage, frequency, and adverse side effects. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

- a. Are there any significant limitations to the student's functioning directly related to the prescribed medications?  NO  YES (please describe) \_\_\_\_\_

\_\_\_\_\_

5. Has the student ever been hospitalized as a result of the condition? NO YES  
If YES, when was the last hospitalization?\_\_\_\_\_
6. What factor(s) improve and/or exacerbate this condition?\_\_\_\_\_
- \_\_\_\_\_
7. How frequently is the student affected by this condition?  
Daily Weekly Monthly Seasonally
8. For allergy patients: Has the student been skin tested by an allergy specialist? If so, what were the results?\_\_\_\_\_
9. For asthma patients: Has the student ever required prednisone to manage the disease? If so, when was the last time? \_\_\_\_\_
10. If the student is not a new first-year or new transfer student, what and/or how has the student's' medical status changed that requires this request?\_\_\_\_\_
11. Are there possible alternatives if the above request is not possible? NO YES  
(please  
state):\_\_\_\_\_
- \_\_\_\_\_

The information provided above is true and accurate:

_____	_____
Signature of Physician/Therapist	Date
_____	_____
License Number	State

**Please Print:**

Physician/Therapist's Name/Title:\_\_\_\_\_

Address:\_\_\_\_\_

Phone:\_\_\_\_\_

Fax:\_\_\_\_\_

**St. Mary's College of Maryland**  
Health/Counseling Services  
Office of Residence Life  
18952 E. Fisher Road  
St. Mary's City, Maryland 20686

Physician/Therapist Special Housing Needs Request Packet

Dear Physician/Therapist,

Your patient has indicated a need for special housing arrangements due to a special medical or psychological condition. We need verification from you that this student has a condition that requires a special housing assignment. Please understand that for a variety of reasons, not all requests can be honored. Therefore, only students with **significant and debilitating conditions will be given priority.**

Please complete the Physician/Therapist Special Housing Needs Request form and return it to the address below. A prescription form or brief memo does **not** include sufficient information for our review process.

Special points:

- There are a very limited number of single rooms available
- We have 10 suites that have semi-private (shared by two students) bathrooms
- Due to limitations of our systems to provide air conditioning, room units will be provided only to students with a clear medically indicated need. Students will incur an additional \$200/year fee for a window air conditioner that is provided by the College. Central air is provided in all academic buildings and some residences, but is only provided from early May 1 – September or October (temperature dependent).
- First year students living in our traditional-style residence halls are required to be on one of three meal plans. All other students living in our traditional-style residence halls are required to be on one of seven meal plans. There is one additional, small meal plan option that townhouse and apartment residents may choose (since they have kitchens in their units).

If you have questions, please call the Health/Counseling Services staff at 240-895-4289 or the Office of Residence Life staff at 240-895-4207. Your assistance with this process is greatly appreciated.

Sincerely,

The Office of Residence Life

Please return the form to:

**Health/Counseling Services**  
**Chance Hall**  
**18952 E. Fisher Road**  
**St. Mary's City, MD 20686**  
**Fax: 240-895-4937**

ST. MARY'S COLLEGE OF MARYLAND  
COUNSELING & HEALTH SERVICES  
18952 E. FISHER ROAD  
ST. MARY'S CITY, MD 20686  
TEL.: 240-895-4289 – FAX: 240-895-4937

AUTHORIZATION FOR RELEASE OF MEDICAL AND MENTAL HEALTH INFORMATION

Name \_\_\_\_\_ Student ID # \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip code \_\_\_\_\_

I authorize: Counseling & Health Services  
St. Mary's College of Maryland

Person or agency authorized to release, receive, and/or exchange health information:

To exchange health information with:

Name \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

And I authorize Counseling & Health Services to release a recommendation on my request for special housing to the Office of Residence Life at St. Mary's College.

Type of disclosure:  Verbal Information  Copies of records

Please specify the information you authorize to be released:

- Mental health information (Subject to Maryland's Confidentiality of Medical Records Act, codified at Health-General § 4-301 et seq.).  
 Medical (This may include, but not limited to, drug/alcohol and mental health information documented by a primary care practitioner)  
 Drug and alcohol abuse, diagnosis or treatment information subject to federal law (42 C.F.R. §§2.34 and 2.35).

Type(s) of information, if not specified above (e.g. Summary Report) \_\_\_\_\_

Specify date(s) of treatment, time period or condition as appropriate: \_\_\_\_\_

Limitations, if any, upon disclosure: \_\_\_\_\_

EXPIRATION OF AUTHORIZATION: Unless otherwise revoked, this Authorization expires on \_\_\_\_\_.

If no date is indicated, the Authorization will expire 12 months after the date of my signing this form.

Client/Patient/Patient Representative Signature \_\_\_\_\_ Date \_\_\_\_\_

Relationship to Client/ Patient:  Self Or  Other, Please specify if not signed by client \_\_\_\_\_

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

**NOTICE:** SMCM and many other organizations and individuals such as physicians, hospitals and health plans are required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

**YOUR RIGHTS:** This Authorization to release health information is voluntary. Treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this Authorization except in the following cases: (1) to conduct research-related treatment, (2) to obtain information in connection with eligibility or enrollment in a health plan, (3) to determine an entity's obligation to pay a claim, or (4) solely to create health information to provide to a third party.

This Authorization may be revoked at any time. The revocation must be in writing, signed by you or your client/patient representative, and delivered to SMCM. The revocation will take effect when SMCM receives it, except to the extent SMCM or others have already relied on it. You are entitled to receive a copy of this Authorization.