Authorization For Release of Information

I, __ x _____, authorize the University Counseling Center
(Print Name)

AGENCY/PERSONS A	***AGENCY/PERSONS B***
UCC Staff Name, Title	Name, Title
University Counseling Center Organization	Organization
P.O. Box 709 Street Address	Street Address
Notre Dame, IN 46556 City, State, Zip	City, State, Zip
574-631-7336 / 574-631-5643 Phone Fax Number	Phone Fax Number

To make the following transaction:
Agency/Person A and B disclose information as specified below to each other.

I authorize the release of the following information: **treatment information, including any relevant drug and alcohol information, Treatment Provider Questionnaire and letter of recommendation on therapist letterhead.**

For the purpose of: **processing readmission request to make a recommendation to the University of Notre Dame.**

This authorization shall remain in effect until: ***one year from the date of signature.***

Acknowledgement: *I understand that upon release and disclosure of the protected medical records and/or information, the records and information may be subject to re-disclosure by the Recipient and may no longer be protected by state or federal privacy regulations.*

I further understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to the University Counseling Center address. No emails will be accepted. However, my revocation will not be effective to the extent that the University Counseling Center Staff has already taken action in reliance on the authorization.

Print Name of Client/Former Client x	Phone x
Signature of Client/Former Client x	Date x
Street Address x	
City, State, Zip x	

Rev. 08/25/15