Authorization For Release of Information

I, __x_____, authorize the University Counseling
(Print Name)

Center (UCC) Staff and the person(s) or agency designated below to disclose protected information from my clinical record to each other:

	Designated Person(s)/Agency
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

I authorize the release of the following specific information: ***type of treatment(s) received, treatment setting, length of treatment, issues addressed, outcome and response to treatment, recommendations for additional treatment and/or follow-up care, and readiness to return to full time study. I also authorize the release of any drug and alcohol information.***

This information is to be released for the purpose of*:* ***informing the UCC's recommendation regarding my readiness to return to full-time study, in connection with my application for readmission to the University.***

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. 2/15/24