Authorization For Release of Information

I, __ x _____, authorize the University Counseling
(Print Name)
Center (UCC) Staff to release protected information from my clinical record to the person(s) or agency designated below:

	Designated Person(s)/Agency
UCC Staff	*John Lubker, Ph.D.*
Name, Title	Name, Title
University Counseling Center	*Associate Dean for Academic Affairs*
Organization	Organization
P.O. Box 709	*The Graduate School – 110 F Bond Hall*
Street Address	Street Address
Notre Dame, IN 46556	*Notre Dame, IN 46556*
City, State, Zip	City, State, Zip
574-631-7336 / 574-631-5643	*(574) 631-5778*
Phone Fax Number	Phone Fax Number

I authorize the release of the following specific information: ***the UCC's recommendations regarding my readiness to return to full time study at the University, which may include mental health or substance misuse treatment information to substantiate this recommendation.***

This information is to be released for the purpose of: ***providing a recommendation to inform the decision-making process regarding 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	

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