

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