

# Authorization For Release of Information

I,   X   \_\_\_\_\_, authorize the University Counseling Center  
(Print Name)

## AGENCY/PERSONS A

UCC Staff

Name, Title

University Counseling Center

Organization

P.O. Box 709

Street Address

Notre Dame, IN 46556

City, State, Zip

574-631-7336 / 574-631-5643

Phone

Fax Number

## AGENCY/PERSONS B

Kevin Doyle O'Rear

Name, Title

Associate Dean for Academic Affairs

Organization

The Law School – 1106 Eck Hall of Law

Street Address

Notre Dame, IN 46556

City, State, Zip

(574) 631-8057

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: **readmission materials, including any relevant drug and alcohol information, requested by the University Counseling Center.**

For the purpose of: **processing readmission request to make a recommendation to the Associate Dean of Academic Affairs.**

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

Signature of Client/Former Client

X

Street Address

X

City, State, Zip

X

Phone

X

Date

X