

# Authorization For Release of Information

I, X \_\_\_\_\_, authorize the University Counseling Center  
(Print Name)  
(UCC) Staff and the designated recipient/agency to request from and/or release to each other protected information  
from my clinical record:

### Designated Recipient / Agency

UCC Staff

Name, Title

Care and Wellness Consultants

Name, Title

University Counseling Center

Organization

Center for Student Support & Care

Organization

P.O. Box 709

Street Address

University of Notre Dame

Street Address

Notre Dame, IN 46556

City, State, Zip

Notre Dame, IN 46556

City, State, Zip

574-631-7336 / 574-631-5643

Phone

Fax Number

574-631-7833 574-631-2133

Phone

Fax Number

I am requesting a release of the following specific information: All relevant clinical data

for the following specific reasons: Continuity of care

I agree to release relevant alcohol and drug information  \_\_\_\_\_  
Initials

### THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM DATE OF SIGNATURE

Special Instructions/Alternative Expiration Date: \_\_\_\_\_

**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