

Authorization For Release of Information

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

AGENCY/PERSONS A

AGENCY/PERSONS B

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

Name, Title

Office of Student Support and Care

Organization

248 Flanner Hall

Street Address

Notre Dame, IN 46556

City, State, Zip

(574) 631-6144

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

For the purpose of: **processing returning documentation and any related issues.**

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