

**UCC Sport Psychology Services
Authorization for the Release of (Limited) Confidential Information**

The University of Notre Dame's University Counseling Center (UCC) is committed to providing comprehensive care for students. To best serve you as a student-athlete, it is sometimes necessary for UCC clinical staff (psychologists, psychiatrists, social workers, licensed counselors) to communicate and coordinate care with your treatment providers in the Athletic Department. By completing this form, you authorize your UCC provider to release specific psychological information in a timely manner with treatment providers that you identify within the Athletic Department to best assure the continuity of your care.

Your decision to sign this form is completely voluntary, and your refusal to sign this Authorization DOES NOT make you ineligible for UCC services.

By initialing the appropriate line(s) below, you are identifying both (i) the types of information that you are authorizing UCC clinical staff to share, and (ii) the personnel within the Athletic Department with whom such information may be shared:

Information to be shared:

- _____ Session dates, attendance, and information related to scheduling
- _____ Treatment recommendations
- _____ Medication compliance and/or reported side effects

Athletic Department personnel with whom identified information may be shared:

- _____ Team Physician(s)
- _____ Athletic Trainer
- _____ Nutritionist
- _____ Other Please specify: _____

All other communications between you and UCC clinical staff will be held in strict confidence and will not be disclosed without your additional written authorization.

The UCC is required by law to keep your psychological information confidential. If you have authorized the disclosure of your confidential information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal privacy laws.

***Acknowledgement:** I understand that this authorization shall remain in effect for one year from today's date, and that I have the right to revoke this authorization at any time before it expires by providing written notification to the University Counseling Center (3rd floor, Saint Liam Hall). 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.*

THIS AUTHORIZATION AUTOMATICALLY EXPIRES ONE YEAR FROM DATE OF SIGNATURE

Signature _____

Printed Name _____

Date _____

Special Instructions/Alternative Expiration Date _____