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	Name, Title
University Counseling Center	*Office of Community Standards (OCS)*
Organization	Organization
P.O. Box 709	*306 Main Building*
Street Address	Street Address
Notre Dame, IN 46556	*Notre Dame, IN 46556*
City, State, Zip	City, State, Zip
574-631-7336 / 574-631-5643	*574-631-5551*
Phone Fax Number	Phone Fax Number

I am requesting a release of the following specific information- attendance and/or treatment participation verification and recommendation**(s)**

for the following specific reasons: to fulfill OSC recommendation and/or mandate

[x] I agree to release relevant alcohol and drug information x__________
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

Rev6/15/21