Authorization For Release of Information

I, __ x _____, authorize the University Counseling Center
(Print Name)
(UCC) Staff to release protected information from my clinical record to the person / agency designated below:

	Designated Recipient / Agency
UCC Staff	*UHS Physicians*
Name, Title	Name, Title
University Counseling Center	*University Health Services*
Organization	Organization
P.O. Box 709	*100 Saint Liam Hall*
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) 631-7497 / (574) 631-6047*
Phone Fax Number	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**

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	Phone x
Signature of Client/Former Client x	Date x
Street Address x	
City, State, Zip x	

Revised 6/25/2020