UNIVERSITY OF
NOTRE DAME

UNIVERSITY HEALTH SERVICES

Saint Liam Hall
Notre Dame, Indiana
46556 USA

tel (574) 631-7497
fax (574) 631-6047
web http://uhs.nd.edu

CONSENT TO ACQUIRE INFORMATION FROM OUTSIDE PROVIDERS

This authorizes ____ to release to:

University Health Services
Saint Liam Hall Room 100
University of Notre Dame
Notre Dame, IN 46556

Any and all information contained in the medical record(s) for:

Name of Patient: ____

Date of Birth: ____

Current Address: ____

Dates of Treatment: ____

Physician: ____

Specific Reports: ____

____

Reason for Disclosure: ____

____

It is understood by the undersigned that he/she may revoke this consent as to his/her medical records/information at any time except to the extent that action has been taken in reliance thereon. It is also understood that this consent shall remain valid for sixty (60) days from the date of signature ***unless*** the consent is revoked prior to the expiration of sixty (60) days ***or*** a date, event, or condition is designated below upon which the consent will expire:

Signature of Patient (or guardian): ________________________________ Date: ____________________

Date of Graduation/Event (if applicable): ________________________