Release of Information for Treating Agent

PERMISSION FOR RELEASE OF INFORMATION

I, ______________________________________, authorize the following agencies/persons:
(Name)

Agency/Persons A	Agency/Persons B
University Health Services Staff Name, Title	____________________ Name, Title
University Health Services Organization	____________________ Organization
Room 201 Saint Liam Hall Street Address	____________________ Street Address
Notre Dame, IN 46556 City, State, Zip	____________________ City, State, Zip
(574) 631-7103 (574) 631-5012 Phone Number Fax Number	____________________ Phone Number Fax Number

To make the following transaction:
_______ Agency/Person A disclose information specified below to Agency/Person B.
_______ Agency/person B disclose information specified below to Agency/person A.
__X____ Agency/Person A and B disclose information specified below to each other.

I authorize the release of the following information: **medical records including hospitalization if any**, **treatment information, and any medication records, Treatment Provider Questionnaire and letter of recommendation on physician's letterhead.**

For the purpose of: **processing readmission request to make a recommendation to the University of Notre Dame.**

This authorization shall remain in effect until*: the end of the academic year for which readmission is sought.*

I understand that I may revoke this consent at any time by giving written notice to the person or organization making disclosure.

____________________ Print Name	____________________ Street Address
____________________ Signature	____________________ City, State, Zip
____________________ Date	____________________ Phone

NOTICE: This information has been disclosed from records, which are confidential. Any further disclosure without the specific written consent of the person to whom it pertains exceeds the limits of this release.