UNIVERSITY OF
NOTRE DAME
UNIVERSITY HEALTH SERVICES

Saint Liam Hall
Notre Dame, Indiana
46556 USA

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AUTHORIZATION TO RELEASE ATHLETE'S MEDICAL RECORDS/INFORMATION

Patient: _____ NDID: _____

Current Address: _____

Date of Birth: _____

Discloser(s)/Recipient(s): (1) Notre Dame Coaches, Athletic Trainers, Sports Nutritionists/Dieticians or any Notre Dame medical physician associated with the care of Notre Dame athletes; (2) University Counseling Center ("UCC") sports psychologist and/or UCC staff psychologists; (3) University Health Services ("UHS")

Address: (1) JACC – Athletic Office, Notre Dame, IN; (2) and (3) Saint Liam Hall, Notre Dame, IN

Disclosers/Recipients are hereby authorized to discuss with and/or release to each other information and/or documentation (including records, reports, tests, histories, diagnosis, prognosis, etc.) obtained or made in connection with evaluation of Patient's medical condition.

Reason for disclosure: ___Continuity of Care with providers and trainers_____

It is understood by the undersigned that he/she may revoke this consent 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 the patient's entire affiliation with Notre Dame as a varsity or non-varsity club sport athlete or until revoked, whichever occurs first.

Signature of Patient (or guardian): _____ Date: _____
Date of Graduation (if applicable): _____

Disclosers/Recipients ARE NOT authorized to release mental health records, alcohol and/or drug treatment records or communicable disease records ("Sensitive Medical Records") unless specifically authorized to do so below.

Sensitive Medical Records Release

By signing below, I hereby authorize Disclosers/Recipients to discuss with and/or release to each other information and/or documentation (including records, reports, tests, histories, diagnosis, prognosis, etc.) from my Sensitive Medical Records, as designated below.

Mental Health _____
Alcohol and/Drug Treatment_____
Communicable Diseases (e.g. – Aids, HIV, hepatitis) _____
Other (Specify) _____

Signature of Patient (or guardian):_____ Date: _____

Physician's Approval: _____ Date: _____