



UNIVERSITY OF NOTRE DAME

UNIVERSITY HEALTH SERVICES

Saint Liam Hall
Notre Dame, Indiana
46556 USA

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fax (574) 631-6047
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Release of Information for Readmissions Committee
Permission For Release of Information

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

Agency/Persons A

Agency/Persons B

\_\_\_\_\_
(Name)

Kevin O'Rear \_\_\_\_\_
(Name)

\_\_\_\_\_
(Title)

Assistant Dean For Academic Affairs \_\_\_\_\_
(Title)

University Health Services \_\_\_\_\_

The Law School \_\_\_\_\_

Saint Liam Hall \_\_\_\_\_

1106 Eck Hall of Law \_\_\_\_\_

Notre Dame, IN 46556 \_\_\_\_\_

Notre Dame, IN 46556 \_\_\_\_\_

P 574/631-7103 F 574/631-5012 \_\_\_\_\_

P 574/631-5410 F 574/631-4789 \_\_\_\_\_

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.
\_\_\_\_\_ Agency/Person A and B disclose information specified below to each other.

I authorize the release of the following information: readmission materials, including any relevant medical information requested by University Health Services.

For the purpose of: processing readmission request to make a recommendation to the Director of Student Services - The Law School.

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 of Client/Former Client

Street Address, City, State, Zip

Signature of Client/Former Client

Phone

Date

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.