Authorization For Release of Information

I, __x_____,
(Print Name)

authorize the University Counseling Center (UCC) Staff AND the person(s) or agency designated below to disclose protected information from my clinical record to each other:

	Designated Person(s)/Agency
UCC Staff Name, Title	*Time Away Coordinator* Name, Title
University Counseling Center Organization	*Center for Student Support and Care* Organization
P.O. Box 709 Street Address	*228 Coleman-Morse* Street Address
Notre Dame, IN 46556 City, State, Zip	*Notre Dame, IN 46556* City, State, Zip
574-631-7336 / 574-631-5643 Phone Fax Number	*574-631-7833* Phone Fax Number

I authorize the release of the following specific information: **verification of appropriateness of the Health Leave of Absence, issues to address, level(s) of care to consider, indications of readiness to resume full-time study, assistance I may need upon my return, and recommendations regarding my readmission application.**

This information is to be released for the purpose of**: providing verification and recommendations related to my Health Leave of Absence and Reinstatement to the University.**

This authorization shall remain in effect until: ***one year from the date of signature.***

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	*Rev. 9/25/24*

Authorization For Release of Information

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

	Designated Person(s)/Agency
UCC Staff	
Name, Title	Name, Title
University Counseling Center	*University Undergraduate Readmissions Committee*
Organization	Organization
P.O. Box 709	*316 Main Building*
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) 631-6144*
Phone Fax Number	Phone Fax Number

I authorize the release of the following specific information: ***the UCC's recommendations regarding my readiness to return to full time study at the University, which may include mental health or substance misuse treatment information to substantiate this recommendation.***

This information is to be released for the purpose of: ***providing a recommendation to inform the decision-making process regarding my application for readmission to the University.***

This authorization shall remain in effect until: ***one year from the date of signature.***

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	

Rev. 2/15/24

Authorization For Release of Information

I, __x_____, authorize the University Counseling
(Print Name)

Center (UCC) Staff and the person(s) or agency designated below to disclose protected information from my clinical record to each other:

	Designated Person(s)/Agency
UCC Staff Name, Title	Name, Title
University Counseling Center Organization	Organization
P.O. Box 709 Street Address	Street Address
Notre Dame, IN 46556 City, State, Zip	City, State, Zip
574-631-7336 / 574-631-5643 Phone Fax Number	Phone Fax Number

I authorize the release of the following specific information: ***type of treatment(s) received, treatment setting, length of treatment, issues addressed, outcome and response to treatment, recommendations for additional treatment and/or follow-up care, and readiness to return to full time study. I also authorize the release of any drug and alcohol information.***

This information is to be released for the purpose of*:* ***informing the UCC's recommendation regarding my readiness to return to full-time study, in connection with my application for readmission to the University.***

This authorization shall remain in effect until: ***one year from the date of signature.***

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	

UNIVERSITY OF NOTRE DAME | STUDENT SUPPORT AND CARE
TIME AWAY SUPPORT

Center for Student Support and Care
Time Away Support
228 Coleman Morse Center
Notre Dame, IN 46556
P 574-631-7833
timeaway@nd.edu

Student Questionnaire

Name: _____

Current Address: _____

Current Phone Number: _____Current Email Address: _____

Signature: _____

Last date of attendance at the University: _____

Applying to return _____Fall _____Spring _____Summer

Today's Date: _____

Your responses to the following questions will be utilized by the UCC to make a recommendation to the University about your readiness to return to full-time study and university life. Please reflect on your experiences and use the following prompts to share the insights you have gained, challenges you have addressed, skills you have learned, how you have addressed the reasons you took time away, and how you will navigate challenges you encounter in the future. Please share enough details to help us understand your experiences during your time away and the support that you may need as you return to the University.

1. Please describe the circumstances involved in your decision to take time away from the University.
2. How have you addressed and resolved the circumstances that precipitated your time away?
3. Please describe changes you have made and/or new skills that you have learned that indicate you are ready to return to full time study.
4. Please describe what steps you will take to support your transition back to the University (academic/campus living/social/athletic/club and/or organizational commitments, etc).
5. Do you plan to continue with mental health treatment as you resume full time study? If yes, please describe your plan.

Revised 7/2026

UNIVERSITY OF NOTRE DAME | STUDENT SUPPORT AND CARE
TIME AWAY SUPPORT

Center for Student Support and Care
Time Away Support
228 Coleman Morse Center
Notre Dame, IN 46556
P 574-631-7833
timeaway@nd.edu

Treatment Provider Questionnaire

This form is to be completed by a licensed mental health provider. Please respond to the questions listed below. **Additionally, a brief letter stating your recommendation regarding the student's readiness to resume full-time academic study is required. This letter must be written on your professional letterhead OR emailed from your professional email account.** Send the completed form and recommendation to the address indicated above.

1. Full name of student: _____

2. Please indicate your clinical licensure: _____

3. Did you provide the treatment for the above-named student? _____ Yes _____ No

Treatment:

4. When did the treatment commence? _____ conclude?_____

If treatment has not yet concluded, how frequently are you currently seeing the student?

_____

5. Describe treatment: (check all that apply) :

☐ Inpatient hospitalization ☐ Residential treatment ☐ Partial Hospitalization

☐ Intensive Outpatient program ☐ Outpatient mental health counseling ☐ Psychiatry

_____

6. How many treatment sessions have you provided for the student? _____

7. List current medication and dose:

_____

_____

Treatment Needs / Recommendations Upon Return to Notre Dame:

8. Will the student need continued medication management? ____ Yes _____ No

Name of provider who will provide medication management:

_____

_____

9. Do you recommend ongoing counseling for the student upon their return to the University? ____ Yes _____ No

If YES, who does the student plan to work with for ongoing counseling?

_____ Continue to work with you via _____ tele-therapy or _____ in-person treatment

_____ Seek services on campus at the University Counseling Center (UCC). Please be aware the UCC utilizes a brief therapy model.

_____ Seek services off-campus in the local community.

Please indicate the name, address, and phone number of the individual or agency:

_____

_____

We strongly recommend that students schedule their initial appointment with off-campus providers prior to returning to campus to avoid delays or gaps in care.

Has the student been in contact with this provider and scheduled an initial meeting? ____ Yes _____ No

10. What goals do you suggest for continued treatment?

_____

_____

_____

11. If you have referred the student for continuing treatment, do you believe they would be able to function appropriately as a student at the University without that continued treatment? _____ Yes _____ No
If No, please explain: _____

12. Do you consider that the student currently, or in the reasonably foreseeable future, may be a threat to their own life or the lives of others? _____ Yes _____ No

List Date of most recent risk assessment and outcome of risk assessment. Include date of most recent in-patient hospitalization (if applicable).

_____

_____

13. In your opinion, is the student capable of carrying a full academic load (12-18 credit) at the University?

_____ Yes _____ No

14. To your knowledge, is the student's family aware of the concern(s)for which you have provided treatment?

_____ Yes _____ No

15. Other comments:

_____

_____

_____

_____

_____

Print Name of Treatment Provider

_____ _____

Signature of Treatment Provider Date

Revised 7/2026