Authorization for Release of Information

(Psychotherapy/Psychological/Psychiatric Notes/Records/Reports, Medical Records, Learning Conditions, Transcripts, Academic Records)

Confidentiality of records is very important to the applicant/seminarian and to Notre Dame Seminary.

To ensure this confidentiality concerning information related to the medical care, psychological counseling/testing/psychiatric/learning disability care a seminarian engages in, as well as his application and academic records during his years of seminary formation, it is important to clearly define who will have access to which records.

I, _____, give my permission for the following people to have access to the documentation described above:

My (Arch)Bishop/Religious Superior, the Rector, Vocation Director, Director of Seminarians, Seminary Counselors, Academic Dean, and my sponsoring (arch)diocese or religious community, during my stay at Notre Dame Seminary. Anyone not named above will require a signed release by me.

The sole purpose for granting permission to access my records is to aid my vocational discernment and personal growth. The rector and seminarian will determine which formation personnel should have access to information so that priestly formation can be embraced in freedom.

This authorization will remain valid from the date of my signature below until I am no longer registered at Notre Dame Seminary.

I acknowledge that I have the right to revoke this authorization at any time, in writing, by sending written notification to the person or organization authorized to release the identified information. However, I understand that any actions already taken in reliance on this authorization cannot be reversed and my revocation will not affect these actions. I understand that to the extent that the information authorized to be released herein relates or refers to mental health records of substance/alcohol abuse, HIV/AIDS, genetic information and/or academic issues, medical and learning issues, this authorization specifically permits the release of such information. I understand that the information to be released may contain confidential information protected by State statute and that State regulations limit the right of persons receiving it to make any disclosure of this information other than that authorized herein without my prior written consent.

The persons, organizations, employees, and officers thereof are released from any legal responsibility or liability for disclosure of the information described to the extent indicated and authorized therein.

Any facsimile, copy, or photocopy of this authorization shall authorize you to release the information described therein.

I certify that I have reviewed this form and that I fully understand its contents. The authorization as described in the document pertains to Notre Dame Seminary only.

Printed Name of Seminarian: _____

Signature of Seminarian: _____ Date: _____