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Authorization for Release of Billing Statement Including Diagnosis

I hereby authorize the Campus Health Service, University of Arizona, to release to (specify insurance company or person authorized to receive information) any information contained in my billing statement as specified below.

Name: _____ Date of Birth: _____

Patient I.D. # _____

Information to be released TO:

Name: _____

Address: _____

City State Zip

Phone: _____

Illness or Injury: _____

Date(s) of Visit: _____

*Gynecology, Genitourinary or Mental Health information must be specifically stated
Or it will NOT be included in the printout.*

I hereby absolve the Campus Health Service and the University of Arizona from all legal responsibility or liability that may arise as a result of this authorization. I understand that this authorization may be revoked at any time prior to release of the above information and will expire 90 days from date of request. Information protected by CFR 42 will not be released unless specified.

Patient Name: _____

Patient Signature: _____

Signature of Parent or Guardian: _____

(If patient is under 18 years of age)

Date of Signature: _____

Accredited by Accreditation Association for Ambulatory Health Care, Inc.