



AUTHORIZATION FOR **RELEASE** OF CONFIDENTIAL HEALTH INFORMATION

I AUTHORIZE _____ /CAPS TO RELEASE INFORMATION FROM: _____ to: _____
(Dates of Service) (Dates of Service)

To: Organization / Individual _____ Myself
Address _____
City _____ State _____ Zip _____
Phone # (_____) _____ FAX # (_____) _____

Method of release: FAXED/Date _____ Mailed to above address/Date _____
 Picked Up/Date _____ Telephone Permission _____

Purpose for release: (initials required)
 Continuity of Care Insurance Claim
 Academic Legal
 Financial Aid Other _____

Information authorized: (initials required)
 Letter/Correspondence Psychiatrist Treatment Summary
 Clinical Records/Notes Psychological Testing
 Treatment Summary Other _____

I hereby release the Campus Health Service and the University of Arizona from any liability that may arise as a result of this authorization. I certify that I gave this consent freely and voluntarily, and understand that my right to receive services is not contingent upon my giving this consent. I may revoke this consent by notifying the CHS Medical Records Department or CAPS in writing at any time, except to the extent that CHS acted on this consent before I revoked it. My consent automatically expires after one year unless an alternate date is specified _____.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the individual or agency who receives the record pertaining to this consent may NOT **redisclose** the record to any individual or agency without a separate written consent from me, unless such recipient is a provider who makes a disclosure permitted by law.

I understand that if I agree to sign this authorization, I must be offered a signed copy of the form.

Signature of Patient (or Legal Guardian/Parent if minor) _____ Print Name _____ Today's Date _____

Description of Authority to sign if legal representative: _____

Student I.D. Number: _____ Date of Birth: _____

Witness Signature _____ Date _____