



THE UNIVERSITY OF ARIZONA.

Counseling & Psychological Services
 Campus Health Service
 Tucson, Arizona 85721
 (520) 621-3334
 FAX (520) 621-8412

Authorization for Release of Information

I, _____ Date of Birth _____
Please Print

hereby authorize _____
 address _____

to release to _____
 address _____

the information indicated below regarding services received for the time period
 from _____ to _____

I am releasing this information for the following purpose(s)

- Continued care Referral source
 Insurance claim Other _____

Report(s) to be furnished (must complete this section)

Check (4)	Initial:	
		Psychiatric/Psychological/Psychosocial history and evaluation
		Psychological testing report
		Clinician's progress notes/discharge summary
		Consultations/laboratory reports
		Letter/medical statement
		Other

I understand that my records are protected under state law and the Federal Confidentiality Regulation (CFR 42, part 2) and cannot be disclosed without my written consent. I certify that this consent has been given freely and voluntarily. I understand that services are not contingent upon my consent for release of information. This consent may be revoked at any time by myself, except to the extent that action has already been taken on this consent and will automatically expire after ninety days.

 Witness

 Signature of patient (or legal guardian)

 Date

 University ID # (or Social Security #)