

Campus Health Service  
P.O. Box 210095  
Tucson, AZ 85721-0095  
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**AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_  
(Please Print) Last First Middle

Information to be released **TO:**

Information to be released **FROM:**

Patient name or/Provider: \_\_\_\_\_ Provider/Agency: \_\_\_\_\_

Address: \_\_\_\_\_ Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

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

\_\_\_\_\_ Continued care \_\_\_\_\_ Insurance Claim \_\_\_\_\_ Other/Explain: \_\_\_\_\_

\_\_\_\_\_ I hereby consent to the release of **ALL** my medical records **EXCEPT** information protected by state/federal law as listed below.

*~ Or ~*

\_\_\_\_\_ I hereby consent to the release of **ALL** my medical records **INCLUDING** information protected by state/federal law related to alcohol and drug abuse, sexually transmitted disease and HIV testing unless otherwise directed below.

\_\_\_\_\_ Counseling and Psychological Services

There is a \$5.00 copying fee for three or more pages.

Specific records only as checked below:

Date(s):

- \_\_\_\_\_ General Medical/Clinician's progress notes
- \_\_\_\_\_ Laboratory/X-ray reports
- \_\_\_\_\_ Gynecology/Genitourinary (i.e. STD's)
- \_\_\_\_\_ Letter/medical statement
- \_\_\_\_\_ Specific diagnosis/other \_\_\_\_\_
- \_\_\_\_\_ Immunizations
- \_\_\_\_\_ TB skin test only

I hereby absolve the Campus Health Service and the University of Arizona from all legal responsibility of 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 the date of request. Information protected by state/federal will not be released unless specified.

\_\_\_\_\_  
Witness Date

\_\_\_\_\_  
Signature of patient (or legal guardian) Date

\_\_\_\_\_  
UA ID number

Accredited by Accreditation Association for Ambulatory Health Care, Inc.