AUTHORIZATION FOR RELEASE OF INFORMATION

CAMPUS HEALTH
Phone: (520) 621-4068
Fax: (520) 626-4301

Patient Name: _____ Date of Birth: _____ Phone #: _____
(Please Print) Last and First

Information to be released **TO**:	Information to be released **FROM**:
Name: _____	Company Name: _____
Address: _____	Address: _____
_____	_____
Phone: _____	Phone: _____
Email: _____	Email: _____
FAX: _____	FAX: _____

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

_____Continued Care _____Insurance Claim _____At the request of the Individual

_____I hereby consent to the release of ALL my medical records EXCEPT information protected by state/ federal law as listed below for these dates of service: _____ to _____.

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, communicable disease, and HIV testing unless otherwise directed below for these dates of service: _____ to _____.

Specific records only as checked/dated below:

_____Immunizations / TB Skin Test Only
_____Clinician's Progress Notes
_____Women's Health
_____Lab Reports (☐ *check here to include STD/HIV)*
_____Specific Diagnosis / Other: _____
_____X-Ray Reports - CD ($0)
_____Letter / Medical Withdrawal-Class
_____Billing Statements / Pharmacy Statements →

*****$6.50 copying fee for 10 or more pages (applies to patient, not legal or insurance).**

☐ Gen Med ☐ Women's Health
☐ Walk-In Clinic ☐ Physical Therapy
☐ Immunizations ☐ CAPS

Expiration Date: This Authorization is good until the following date: _____ or for one year from the date signed below.

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 information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.
I understand that I am entitled to a signed copy of this form. **Right to Refuse to Sign This Authorization-** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.
Right to Withdraw This Authorization- I understand written notification is necessary to cancel this authorization by submitting my written request to: The University of Arizona, P.O. Box 210095, Tucson, AZ 85721-0095 or via fax to: (520) 621-9471. I may revoke this consent at any time except to the extent that action based on this authorization has already been taken.
I have had an opportunity to review and understand the content of this authorization form. By signing this Authorization, I am confirming that it accurately reflects my wishes.

_____ UA ID# _____ Date _____
Signature/Electronic Signature of Patient or Legal Guardian

Description of Authority to Sign if Legal Representative: _____

This form must be submitted with photo identification.