AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Services

I authorize: _____ / CAPS to release information

from (dates of service): _____ to _____

TO: Organization / Individual: _____ ☐ Myself

Address: _____

City: _____ State: _____ Zip: _____

Phone: (_____) _____ Fax: (_____) _____

METHOD OF RELEASE:
(initials required)

☐ Faxed / Date _____ ☐ Mailed to above address / Date _____

☐ Picked up / Date _____ ☐ Telephone Permission _____

PURPOSE FOR RELEASE:
(initials required)

	Initials		*Initials*
☐ 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 _____	_____
☐ Phone Communication	_____		

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 **re-disclose** 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.

Student Signature (Parent/Legal Guardian if minor)	Print Name	Date

Description of Authority to sign if legal representative: _____

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

Witness Signature	Print Name	Date

LABEL

CAPS F-GENADM 9/2015

COUNSELING AND PSYCH SERVICES
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