

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)

<input type="checkbox"/> Continuity of Care _____	<u>Initials</u>	<input type="checkbox"/> Insurance Claim _____	<u>Initials</u>
<input type="checkbox"/> Academic _____		<input type="checkbox"/> Legal _____	
<input type="checkbox"/> Financial Aid _____		<input type="checkbox"/> Other _____	

INFORMATION AUTHORIZED: (initials required)

<input type="checkbox"/> Letter / Correspondence _____	<input type="checkbox"/> Psychiatrist Treatment Summary _____
<input type="checkbox"/> Clinical Records / Notes _____	<input type="checkbox"/> Psychological Testing _____
<input type="checkbox"/> Treatment Summary _____	<input type="checkbox"/> Other _____
<input type="checkbox"/> 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.

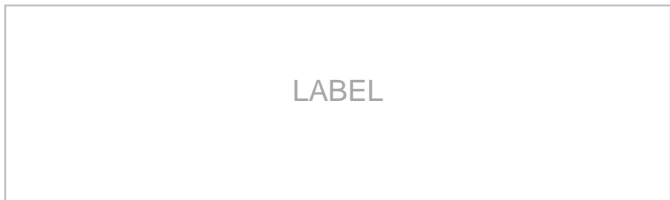
I understand that if I agree to sign this authorization, I must be offered a signed copy of the form.

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



CAPS F-GENADM 9/2015

COUNSELING AND PSYCH SERVICES

The University of Arizona / Campus Health Service
P.O. Box 210095 Tucson, AZ 85721-0095
Phone: 520-621-3334 FAX: 520-626-6105
www.health.arizona.edu