AUTHORIZATION FOR REQUEST OF CONFIDENTIAL HEALTH INFORMATION

THE UNIVERSITY OF ARIZONA
CAMPUS HEALTH
Counseling & Psych Services

I authorize the office designated below to release my health information to Counseling and Psych Services, The University of Arizona
from (dates of service): _____ to _____
Date you started seeing provider *Present*

FROM: *Information on Provider*
Organization / Individual: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: (_____) _____ Fax: (_____) _____

Please fax or mail records to:

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

PURPOSE FOR REQUEST AND INFORMATION AUTHORIZED ***(INITIALS REQUIRED)***

	Initials		*Initials*
☐ ADHD Testing Results	_____	☐ Letter/Correspondence	_____
☐ Assessment / Evaluation	_____	☐ Psychiatrist Treatment Summary	_____
☐ Attendance	_____	☐ Psychological Testing	_____
☐ Clinical Records / Notes	_____	☐ Telephone Communication	_____
☐ Continuity of Care	_____	☐ Treatment Summary/Content	_____
☐ Lab Reports	_____	☐ Other _____	_____

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 Immuno-deficiency 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.
Be sure you sign here

_____ _____ _____
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 Witness Name Date
Have someone in provider's office witness your signature.

LABEL

CAPS F-GENADM 2/2016