

# 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:** Organization / Individual: \_\_\_\_\_  
*Information on Provider* 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

	<u>Initials</u>	<u>Initials</u>
<b>PURPOSE FOR REQUEST AND INFORMATION AUTHORIZED (INITIALS REQUIRED)</b>	<input type="checkbox"/> ADHD Testing Results _____	<input type="checkbox"/> Letter/Correspondence _____
	<input type="checkbox"/> Assessment / Evaluation _____	<input type="checkbox"/> Psychiatrist Treatment Summary _____
	<input type="checkbox"/> Attendance _____	<input type="checkbox"/> Psychological Testing _____
	<input type="checkbox"/> Clinical Records / Notes _____	<input type="checkbox"/> Telephone Communication _____
	<input type="checkbox"/> Continuity of Care _____	<input type="checkbox"/> Treatment Summary/Content _____
	<input type="checkbox"/> Lab Reports _____	<input type="checkbox"/> 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.

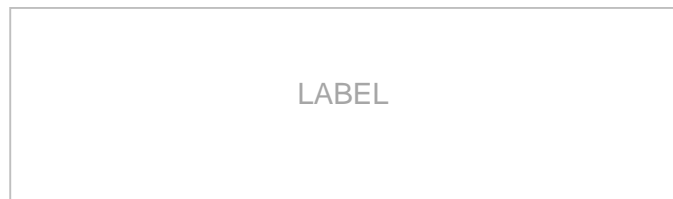
*Be sure you sign here*

\_\_\_\_\_  
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.*



CAPS F-GENADM 2/2016

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www.health.arizona.edu

Fully accredited by the Accreditation Association for Ambulatory Health Care (AAAHC), Inc.