CAMPUS HEALTH

THE UNIVERSITY OF ARIZONA
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize_____ to disclose the following information from the health records of:

STUDENT/PATIENT:

_____ _____ _____ _____

Name | Birth Date | SID# | Phone Number

_____ _____

Street Address: | City, State, Zip:

I authorize the following persons (or class of persons) to receive my health information in the following format:

Name:_____ Phone:_____

☐**Paper Copies**. Mail paper copies to the following mailing address:_____

☐**Fax.** Fax the information to the following fax number:_____

☐**In person**. Specify preferred date and time (*must be within posted office hours*):_____

☐**Email**.* Email electronic copies to the following email address:_____

**CHS uses a secure message email under NeoCertified (neocertified.com). You will create a login, access the record and the record will be available for up to 6 months from the date you sign this form. If you would like to request that your records be transmitted via email outside of NeoCertified, you may do so, but recognize that email transmission outside of NeoCertified will not be secure. By initialing here:_____ and signing this form, you request that CHS transmit your records via insecure email and acknowledge that you understand the risks involved in sending your health information via insecure email, including that it may be intercepted, forwarded, printed, and stored by others. You also understand that The University of Arizona is not responsible for the unauthorized access of health information while in transmission to the third party named above and is not responsible for safeguarding your information once it is delivered to the third party named above.*

**NOTE: I understand that I may be charged a reasonable, cost-based fee that includes the labor for copying the information (whether in paper or electronic format), supplies for creating the copy, or preparation of an explanation or summary of the health information.

INFORMATION TO BE RELEASED, Including verbal information (*check as applicable*):

☐History & Physical	☐Surgical Reports	☐Consultations	☐Sexually Transmitted Disease	☐Genetic Testing
☐Treatment/Tests	☐Hospital Records & Reports	☐X-Ray reports	☐Other Communicable Diseases	☐Drug/ Alcohol Treatment
☐Allergy Records	☐Laboratory Reports	☐HIV/AIDS	☐Immunizations	☐Developmental/ Behavioral/Psychiatric
☐Prescriptions	☐Other (Specify):_____			

-OR-

☐ **Entire record** including the following (***check as applicable***):

☐ Sexually Transmitted Disease ☐ HIV/AIDS ☐ Other Communicable Diseases ☐Genetic Testing

☐ Developmental/Behavioral/Psychiatric Care ☐ Treatment of Alcohol and/or Drug Abuse

FOR THE FOLLOWING Date(s) of Service:

From_____

To_____

PURPOSE OF DISCLOSURE *(check all applicable categories):*

☐Legal Investigation or Action ☐Medical Hardship Waivers

☐Further Medical Care/Continuity of Care ☐Insurance Eligibility/Benefits

☐At Request of Individual ☐Other (specify):_____

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. I release The University of Arizona, its employees, and its agents from any legal responsibility or liability for the disclosure of the above information.

SIGNATURE PATIENT/LEGAL REP _____ DATE: _____

Description of Authority to Sign if Legal Representative: _____