Counseling & Psych Services (CAPS)
Campus Health Service
The University of Arizona
P.O. Box 210095
Tucson, Arizona 85721-0095

CAPS Phone: (520) 621-3334
CAPS FAX: (520) 626-6105

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

I AUTHORIZE _____ ***/CAPS TO RELEASE INFORMATION FROM:*** _____ ***to:*** _____
(Dates of Service)

To: Organization / Individual _____ ❒ Myself ◯

Address _____

City _____ State _____ Zip _____

Phone # (_____) _____ FAX # (_____) _____

Method of release: ❒ FAXED/Date _____ ❒ Mailed to above address/Date _____
❒ Picked Up/Date _____ ❒ Telephone Permission _____

Purpose for release:
(initials required)

- ❒ 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 **redisclose** 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.

_____ _____ _____
Signature of Patient (or Legal Guardian/Parent if minor) Print Name Today's Date

Description of Authority to sign if legal representative: _____

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

_____ _____ _____
Witness Signature Print Witness Name Today's Date

(Patient Label)

CHS 39a
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