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
☐ Faxed / Date	________		
☐ Picked up / Date	________	☐ Telephone Permission	________
☐ Mailed to above address / Date	________	☐ Email permission	________

PURPOSE FOR RELEASE:
(initials required)

	Initials		*Initials*
☐ 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 **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.

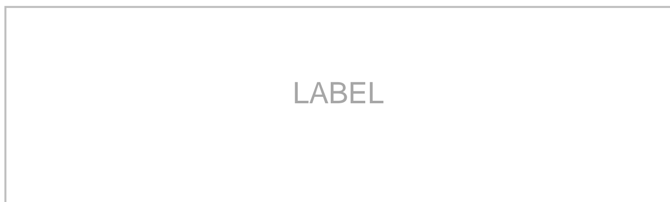
I understand that if I agree to sign this authorization, I must be offered a signed copy of the form.

____________________	____________________	____________________
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



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