CAPS AUTHORIZATION FOR RELEASE OF CONFIDENTIAL HEALTH INFORMATION

CAMPUS HEALTH

Phone: (520) 621-4068
Fax: (520) 626-4301

Patient Name:_____ Date of Birth:_____ Phone #: _____
(Please Print) *Last and First*

I authorize Campus Health Service/CAPS to: ☐Release ☐Request ☐Exchange information with:

☐Dean of Students ☐Housing & Residential Life ☐Palo Verde Behavioral Health
☐Banner Crisis Response Center ☑Other (Please specify below):

Name: _____

Address: _____

_____

Phone: _____

Email: _____

FAX: _____

I am releasing this information for the following purpose(s):

_____ Continued Care _____ Insurance Claim _____ At the Request of the Individual
_____ Legal _____ Other (Please specify)_____

_____ I hereby consent to the release of **ALL my CAPS** records for dates of service _____ to _____.

OR

_____ I hereby consent to the release of my **CAPS records as indicated below** for dates of service _____ to _____ .

*****$6.50 copying fee for 10 or more pages (applies to patient, not legal or insurance**

Specific records only as checked below:

_____ Clinician's Progress notes _____ Psychiatrist Treatment Summary
_____ Letter / Correspondence _____ Psychological Testing _____ Lab results
_____ Treatment Summary _____ Billing Statements _____ Medication List
_____ Phone communication _____ ADHD Testing Results
_____ Other (Please specify)_____

Expiration Date: My consent automatically expires after one year from the date of signature unless an **earlier** alternate date is specified: _____ (cannot be extended past one year from date of signature).

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.

_____ UA ID# _____ Date _____
Signature/Electronic Signature of Patient or Legal Guardian

Description of Authority to Sign if Legal Representative: _____

This form must be submitted with photo identification.