ASU Counseling Services
Medical Records Department
P.O. Box 872104 Tempe, AZ 85287-2104
Phone 480.965.1359 Fax 480.965.6531

CONSENT AND AUTHORIZATION FOR RELEASE OF CONFIDENTIAL AND PROTECTED HEALTH INFORMATION

Please print. *Incomplete forms **WILL NOT** be processed.* See reverse side for instructions and fees.

1. PATIENT WHOSE INFORMATION IS TO BE RELEASED

Name _____ ASU ID# _____
(First) (Middle Initial) (Last) (Previous name) (10 digit number)

Date of Birth ____ / ____ / ____ Phone _____
Month Day Year

Address: _____ City / State / Zip: _____

2. PERSON / ORGANIZATION WHO IS RECEIVING OR RELEASING INFORMATION

I hereby authorize ASU Counseling Services to: Choose **ONE** option: ☐Release To ☐Obtain From ☐Copy to Self (No need to fill in the information below)

Name / Facility _____

Address _____ City /State /Zip _____

Phone Number _____ Fax Number _____

3. TYPE OF INFORMATION TO BE RELEASED

Records subject to this authorization: ***Please note:*** Copy fees may be charged (see back for details).

3A. Check the following if such categories should also be included. **Records in these categories will not be released unless checked.**

☐HIV Related ☐ Drug/Alcohol Abuse Treatment ☐Mental Health Records ☐Communicable Disease ☐Genetic Testing

3B ☐Complete copy of patient file ***OR*** only the following categories: ☐Clinical Summary ☐Discharge Note ☐Psychotherapy Notes

☐Treatment Progress ☐Attendance ☐Other _____

4. DATES OF INFORMATION TO BE RELEASED Future dates of service will not be honored

Information released will fall within this date range _____ to _____
Month / Day / Year Month / Day / Year

5. METHOD OF RELEASE

Information will be released by: (select ***only*** one) ☐Send to Health Portal ☐Office Pick Up ☐Fax ☐ Mail (We do not email records)

6. PURPOSE OF RELEASE

☐Personal Use ☐Continued Care ☐Academics ☐Employment ☐Legal ☐Other (Specify)_____

7. PATIENT RIGHTS AND SIGNATURE

I understand that this authorization is **valid for 60 days** unless revoked by written notice, provided said notice is received prior to the release of the above-designated information. I understand that authorizing the disclosure of my health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment. I understand there may be a charge for record copies. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure of this health information, which may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact the ASU Counseling / Health Services Information Manager.

_____ _____ _____
Signature of Patient or ** Authorized Representative Date (Month / Day / Year) **Authorized Relationship (if not the patient)

**Paperwork must be submitted with this request

FOR OFFICE USE ONLY

Processed By _____ Date_____ ☐HP ☐P ☐M ☐F # of pages released _____

Amount billed $_____ Invoice # _____ CS Approval: _____

Instructions: All sections must be completed for this form to be processed.

1. Patient Information: Complete the entire section to clearly and legibly identify the patient – The entire patient's name (and any previous names), Date of birth, phone number, and address.

2. Receiving Party: The full name/organization, address, phone, and fax number of the recipient. If the request is to release records, please allow 7-10 business days for processing.

- Requesting ASU Counseling Clinical and Psychiatric Information will require additional approvals and may increase processing time.

3. Information to be released: Be specific about the information you need to be released. For example, the types of visits or the name of the physician or provider who treated you.

3A. Check the boxes of the medical information you wish to release. If your chart notes or labs include any of the information in 3A and the boxes are not checked, the information will not be released.

3B. Check the box(es) for the type of medical information you want released.

4. Dates to be Released: This can be a very specific date or more general. For example, April 25, 2019, or April 25, 2019, to April 25, 2021. You may ***not*** request future dates of service. For example, if you complete this form on April 25, 2021, you may not authorize your release for appointments or services scheduled on May 1, 2021.

5. Method of Release: How will your information be delivered? Select only one method, and provide the address, fax number in section 2 (see above).

6. Purpose of Release: Please identify the need for a copy of your record. This helps us to track and assign priority status to your request. It also informs us who may be responsible for the cost of records (where appropriate).

7. Rights/Signature: Your or your authorized representative's handwritten signature and date are required. If your authorized representative will sign this form, documentation proving they are authorized to do so must be submitted along with this request.

Fee schedule: In accordance with Arizona Revised Statutes 12-2295 and 12-351

Provider / Health care Facility:	No Charge (Records must be mailed/Faxed to the provider listed)
Immunization records:	No Charge
Personal Copy: Sent to your Health Portal:	No Charge
Printed copy to Patient:	1 - 10 Pages – No Charge 11 - 50 Pages – $5.00 51 - 149 Pages – $10.00 150 Pages and above – $15.00
Attorney and Insurance company:	$25.00 Administration Fee plus $0.25 per page