

AUTHORIZATION FOR RELEASE PATIENT HEALTH INFORMATION

ASU Health Services Medical Records Department P.O. Box 872104 Tempe, Arizona 85287-2104
Phone: 480-965-1359 Fax: 480-965-6531

Action Requested:

I request ASU Health Services to **RELEASE** my medical records to the following:

SELF

OR

Name: _____

Street Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

Mail Pick Up Fax

I request ASU Health Services to **RECEIVE** my medical records from the following:

Name: _____

Street Address: _____

City / State / Zip: _____

Phone: _____ Fax: _____

Mail Pick Up Fax

Type of Medical Information Requested:

Please note: Copy fees may be charged for medical records (see backside for details)

Immunizations Complete Medical Record Medical Withdraw: _____ Date(s) Clinic Notes _____ Date(s)

Lab Reports: _____ Date(s) Sport Physical Clearance _____ Date(s) Radiology Reports: _____ Date(s)

Pharmacy Records: _____ Date(s) Other _____ Date(s)

Purpose of request:

Continuing Care Coordination with School Employment Purposes Insurance Legal Personal Use Referral

Other _____

Patient Name: _____ ASU ID#: _____
(First) (Middle Initial) (Last)

Date of Birth: _____ / _____ / _____ Phone: _____
(MM/DD/YYYY)

Street Address: _____ City / State / Zip: _____

X _____
Signature of Patient or Legally Responsible Representative Date (MM/DD/YYYY)

Unless specifically excluded, this authorization includes: Confidential HIV-Related information, Confidential Communicable Disease Related information, Confidential Alcohol or Drug Abuse related information, Mental Health Diagnosis/Treatment information

This authorization will expire automatically six months from the date it is signed. I understand I may revoke this authorization at any time by written notice. My cancellation will take place when Medical Records receives my written notice, but will not affect information previously released. If I have questions about the disclosure of my health information, I can contact the Medical Records Manager. Important: *This information is subject to re-disclosure.*

Internal Use Only: Processed by _____ M P F Date _____ # of pages released _____
Amount Charged _____

ASU HEALTH SERVICES MEDICAL RECORD COPYING FEES

COPIES TO PATIENT

1-10 pages – NO FEE

11- 50 Pages – \$5.00

51-149 Pages - \$10.00

Charts over 150 pages - \$15.00 plus \$0.10/page

EQUIVALENCY STATEMENT \$10.00

RECORDS FAXED OR MAILED FOR CONTINUING CARE - NO FEE