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