CONSENT TO DISCLOSE HEALTH CARE INFORMATION

I, _____ (patient name) ASU ID # _____, hereby give my consent for the following individuals to act on my behalf in scheduling my treatment, discussing my treatment and handling my finances concerning my health care treatment at an ASU Health Services location.

_____	_____
Name	Relationship
_____	_____
Name	Relationship
_____	_____
Name	Relationship

I will notify ASU Health Services if I want to add or remove individuals from this list.

_____	_____
Patient Signature	Date

Please submit all completed forms to ASU Health Services:

Medical Records
ASU Health Services
Arizona State University
PO Box 872104
Tempe, AZ 85287-2104

FAX: 480-965-6531