ARIZONA STATE UNIVERSITY

# ASU HEALTH SERVICES

AUTHORIZATION FOR **VERBAL RELEASE** OF MEDICAL INFORMATION

| LAST NAME | FIRST NAME | A.S.U. ID# |
|---|---|---|
| | | |

| MAIN TELEPHONE # | ALTERNATIVE TELEPHONE # |
|---|---|
| | |

I HEREBY AUTHORIZE ASU HEALTH SERVICE TO **VERBALLY** RELEASE AND DISCUSS MY MEDICAL INFORMATION WITH*:*

| NAME(S) | RELATIONSHIP TO PATIENT |
|---|---|
| | |

| MAIN TELEPHONE # | ALTERNATIVE TELEPHONE # |
|---|---|
| | |

**ATTENTION:** _____
**CLINICIAN NAME**

## CHECK APPROPRIATE BOX:

☐ **Complete Medical Information**

☐ **Specific Medical Information ONLY** _____

☐ **Exclude** _____

***Unless specifically excluded, this authorization includes:***
**ALL 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 GIVING ASU HEALTH SERVICES 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 DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE MEDICAL RECORD MANAGER.***

**X** Patient's ***Written Signature*** _____ Date _____

☐ Patient's ***Verbal Authorization*** by telephone conversation with:

**WITNESS 1**_____ Date _____

**WITNESS 2**_____Date _____