Arizona State University

ASU Health 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 Health Services to: Choose **ONE** option: ☐Release To ☐Obtain From ☐Copy to Self (No need to fill in 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).

☐Complete copy of patient file ***OR*** only the following categories:

☐Office Notes ☐Lab Reports ☐Radiology Reports ☐Sports Medicine ☐Immunizations ☐Result of evaluations

☐Other ______________________________

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

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 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 Health Services Information Manager.

______________________________ ______________ ______________
Signature of Patient or **Legal Representative Date (Month / Day / Year) Legal 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 # ______________ Ordering Provider: ______________

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

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

2. Receiving Party: Identify 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.

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

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 be sure to provide address, fax number in section number 2 (see above).

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

7. Rights/Signature: Your handwritten Signature and date of form completion are required.

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