

# 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: (Choose only one, either to release or receive).**

<input type="checkbox"/> I request ASU Health Services to <b>RELEASE</b> my Medical records to the following: <input type="checkbox"/> <b>Self</b> <input type="checkbox"/> <b>OR</b> (fill out the box below)	<input type="checkbox"/> I request ASU Health Services to <b>RECEIVE</b> my medical records from the following:(fill out the box below)
Name of facility: _____	
Address: _____	
City/State/Zip: _____	
Phone: _____	Fax: _____

## Type of Medical Information Requested:

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

<input type="checkbox"/> Immunizations	<input type="checkbox"/> Complete Medical Record	<input type="checkbox"/> Medical Withdraw: _____ Date(s)	<input type="checkbox"/> Clinic Notes _____ Date(s)
<input type="checkbox"/> Lab Reports: _____ Date(s)	<input type="checkbox"/> Sport Physical Clearance _____ Date(s)	<input type="checkbox"/> Radiology Reports: _____ Date(s)	
<input type="checkbox"/> Pharmacy Records: _____ Date(s)	<input type="checkbox"/> Other _____ Date(s)		

## Purpose of request:

<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Coordination with School	<input type="checkbox"/> Employment Purposes	<input type="checkbox"/> Insurance	<input type="checkbox"/> Legal	<input type="checkbox"/> Personal Use	<input type="checkbox"/> Referral
<input type="checkbox"/> 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 \_\_\_\_\_ Date \_\_\_\_\_  **M**  **P**  **F** # of pages released \_\_\_\_\_  **E**  
F.O. By: \_\_\_\_\_ Date \_\_\_\_\_ Amount Charged \$ \_\_\_\_\_

ASU HEALTH SERVICES MEDICAL RECORD COPYING FEES

Copies via Patient Portal - NO FEE

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

RECORDS FAXED OR MAILED FOR CONTINUING CARE - NO FEE