

**University of Denver Health and Counseling Center  
Denver, CO 80208  
Tel: 303-871-2205 Fax: 303-871-4242**

**Authorization for Release of Information**

**Patient Information:**

Patient Name: \_\_\_\_\_ DU ID # \_\_\_\_\_  
(Last) (First) (MI)

Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ Day Phone Number: \_\_\_\_\_  
Mo Day Yr

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

**I hereby authorize the release of information from my medical record as indicated below:**

**Records Released From:**

**Records To Be Sent To:**

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Address: \_\_\_\_\_

City, State, Zip \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Information to be Released:**

- Copy of complete medical records generated in this office. (See section below for release of information regarding alcohol or drug use/abuse, HIV testing, psychological or psychiatric conditions, learning disabilities or attention deficit disorders.)
- Copy of complete medical record, including records received from other providers. These records could contain information that is sensitive to you. We may not have read everything in the records and may not know whether they contain such sensitive information.
- Copy of medical record covering period of time from \_\_\_\_\_ to \_\_\_\_\_
- Laboratory reports dated \_\_\_\_\_ to \_\_\_\_\_
- X-ray reports dated \_\_\_\_\_
- Verbal communication regarding visits dated \_\_\_\_\_
- Other (specify): \_\_\_\_\_

**I specifically authorize the release of information relating to:**

- Substance abuse (including alcohol/drug abuse)
- Mental health
- Mental health (including psychotherapy notes)
- HIV-related information/testing
- Learning disabilities/attention deficit disorder

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Purpose of Disclosure:**    \_\_\_ Changing providers    \_\_\_ Consultation/second opinion    \_\_\_ Legal

\_\_\_ Continuing care    \_\_\_ School    \_\_\_ Insurance    \_\_\_ Workers Comp

\_\_\_ Other (specify): \_\_\_\_\_

**I understand that:**

1. This authorization will expire on \_\_\_\_\_ (Print the Date this Form Expires), 180 days after I have signed the form.
2. I may revoke this authorization at any time by notifying the providing organization in writing, and the revocation will be effective on the date notified, except to the extent action has already been taken in reliance upon the initial authorization.
3. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal Privacy Regulations.
4. Signing or not signing this authorization will not affect my health care or payment for health care at the DU Health & Counseling Center. However, I understand that my health care may be affected if my health care providers are not able to obtain information pertinent to my health condition and treatment.
5. I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
6. The DU Health & Counseling Center will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.
7. In compliance with Colorado statute, I will pay a reasonable fee for copying and transferring my health care information. There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

**PRINT NAME:** \_\_\_\_\_

**FOR OFFICE USE ONLY**

**DATE REQUEST FILLED:** \_\_\_\_\_ **BY:** \_\_\_\_\_

**IDENTIFICATION PRESENTED:** \_\_\_\_\_ **FEE COLLECTED: \$** \_\_\_\_\_

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