University of Denver, Health and Counseling Center
2240 E Buchtel Blvd 3N
Denver, CO 80208-3230
Tel: (303) 871-2205 Fax: (303) 871-4242

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Information:

Patient Name:_____ DU ID #_____

Date of Birth:_____Contact Phone Number: _____

Address:_____City:_____State:_____Zip:_____

I authorize University of Denver, Health and Counseling Center to:

☐ Release the following information **to**: ☐ Receive the following information **from**:

Name of Facility/Person:_____

Address/City, State, Zip:_____

Fax number (if information is to be faxed)_____

Description of information to be used or disclosed *(check all that apply):*

NOTE: Copying Fees: pages 1-4 = $0.00
pages 5-9 = $5.00
pages 10+ = $0.25 ea.

☐ The patient's entire medical record generated in this office
☐ Medical Data/Information related to:
- ☐ Radiology (specify):_____ ☐ Laboratory Tests (dates)_____
- ☐ Immunizations:_____ ☐ Gynecological, inc.pap smears (dates)_____
- ☐ Verbal Communication (visit date)_____ ☐ Other (specify):_____

The following information will not be released unless you specifically authorize it by checking the relevant box(es) below:

- ☐ information pertaining to drug and alcohol abuse
- ☐ information pertaining to mental health
- ☐ information pertaining to psychotherapy notes
- ☐ release of HIV/AIDS testing results

Purpose of Disclosure:*(check one)*

☐ Health Care ☐ Insurance ☐ Legal ☐ School ☐ Employment/Internship
☐ Other (specify):_____

This authorization will expire 6 months from the date it is signed unless a shorter time is indicated here:_____
You 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 disclosure made prior to receipt. Information disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected under Federal Privacy Regulations. DU Student Health and Counseling cannot require you to sign this Authorization as a condition to the provision of services; however, your health care may be affected if your providers are not able to obtain information pertinent to your condition and treatment. You have a right to request a copy of this Authorization after signing it, and agree to pay reasonable copying fees (in compliance with Colorado statute) if records are not being sent to another medical/mental health facility.

_____

Signature of Patient or Legal Representative *Date Signed*