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/Client 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:_____

Phone number: _____ Fax number: _____

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** (not including mental health) record generated in this office
☐ Medical Data/Information related to: ☐ HIV/AIDS testing results
☐ Radiology (specify):_____ ☐ Laboratory Tests (dates)_____
☐ Immunizations:_____ ☐ Gynecological, inc.pap smears (dates)_____
☐ Verbal Communication (visit date)_____ ☐ Other (specify):_____
☐ The client's **mental health** record generated in this office (indicate specifics below)
☐ Mental Health Data/Information related to:
☐ 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 mental health visit attendance
☐ information pertaining to mental health treatment notes
☐ information pertaining to psychological assessment

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*

For Administrative Use Only

☐ **ROI Complete. No Further Action Necessary.** ☐ **ROI not complete. Records to be sent by HCC Records Department.**