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).

[X] I request ASU Health Services to **RELEASE** my Medical records to the following: ☐ **Self** [X] **OR** **(fill out the box below)**	☐ I request ASU Health Services to **RECEIVE** my medical records from the following: **(fill out the box below)**

Name of facility: **RECORDS DEPOSITION SERVICE, INC.**

Address: **PO BOX 5054**

City/State/Zip: **SOUTHFIELD, MI 48086-5054** **REQUESTS@RECDEP.COM**

Phone: **248.357.3330** Fax: **248.357.3337**

Type of Medical Information Requested:

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

☐ Immunizations ☐ Complete Medical Record ☐ Medical Withdraw: ____________ Date(s) ☐ Clinic Notes ____________ Date(s)

☐ Lab Reports: ____________ Date(s) ☐ Sport Physical Clearance ____________ Date(s) ☐ Radiology Reports: ____________ Date(s)

☐ Pharmacy Records: ____________ Date(s) ☐ Other ____________ Date(s)

Purpose of request:

☐ Continuing Care ☐ Coordination with School ☐ Employment Purposes ☐ Insurance [X] Legal ☐ Personal Use ☐ Referral

☐ Other ____________

Patient Name: ____________ (First) (Middle Initial) (Last) **ASU ID#:** ____________

Date of Birth: ______ / ______ / ______ (MM/ DD/ YYYY) **Phone:** ____________

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 $_____._____

Revised 2019