UNIVERSITY OF ARIZONA
AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

I authorize ______________________________ **to disclose the following information from the health records of:**

STUDENT/ PATIENT:

Name ______________________ Birth Date ____________ SID# ____________ Phone Number ____________

Street Address ______________________ City, State, Zip ______________________

I authorize the following persons (or class of persons) to receive my protected health information:

Name: RECORDS DEPOSITION SERVICE, INC.
Address: 120 W. MADISON STREET, SUITE 300
City/State/Zip: CHICAGO / IL / 60602 Phone: 312-553-8900 FAX: 312-553-8901

INFORMATION TO BE RELEASED (check as applicable):

___ History & Physical ___ Surgical Reports ___ Consultations ___ Sexually Transmitted Disease ___ Genetic Testing
___ Treatment or Tests ___ Hospital Records & Reports ___ X-Ray Reports ___ Other Communicable Disease ___ Drug/Alcohol Treatment
___ Allergy Records ___ Laboratory Reports ___ Immunizations ___ HIV/AIDS ___ Developmental/Behavioral/ Psychiatric
___ Prescriptions [✓] Other (Specify): PLEASE SEE ATTACHED SUBPOENA OR LETTER REQUEST

- or -

___ **Entire Record** excluding the following (**CIRCLE** as applicable): Sexually Transmitted Disease; HIV/AIDS; Other Communicable Diseases; Genetic Testing; Developmental/Behavioral Health Care/Psychiatric Care; or Treatment of Alcohol and/or Drug Abuse

For the Following Date(s) of Service: From ______________ To ______________

PURPOSE FOR DISCLOSURE: (Check applicable categories)

___ Further Medical Care/Continuity of Care ___ Medical Hardship Waivers ___ Other (Specify): ______________
[✓] Legal Investigation or Action ___ Insurance Eligibility/Benefits

EXPIRATION DATE: This authorization is good until the following date: ______________ or for one year from the date signed.

I understand information in my health record may include information relating to Sexually Transmitted Disease, Acquired Immunodeficiency Syndrome (AIDS), Human Immunodeficiency Virus (HIV) and other communicable diseases, genetic testing, Developmental/Behavioral Health/Psychiatric Care, and treatment of alcohol and/or drug abuse. My signature authorizes such release as indicated above. I understand that the information disclosed by this authorization may be subject to redisclosure by the recipient and no longer protected by the Health Insurance Portability and Accountability Act of 1996 or other applicable federal and state law. However, redisclosure by school officials may be subject to student education records privacy laws.

I understand that if I agree to sign this authorization, I may keep a signed copy of the form. **Right to Refuse to Sign This Authorization -** I understand that I am under no obligation to sign this form and that the person(s) and/or organization(s) listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization. **Right to Withdraw This Authorization -** I understand written notification is necessary to cancel this authorization by submitting my written request to: Campus Health Service, ATTN: Medical Records, PO Box 210095, Tucson, AZ 85721-0095. I may revoke this consent at any time except to the extent that action based on this authorization has already been taken.

I have had an opportunity to review and understand the content of this authorization form. By signing this authorization, I am confirming that it accurately reflects my wishes. I release the University of Arizona, its employees and agents from any legal responsibility or liability for the disclosure of the above information.

SIGNATURE PATIENT/LEGAL REP: ______________________________ **DATE:** ______________