University of Denver Health and Counseling Center
2240 E Buchtel Blvd 3N, Denver, CO 80208-3230
Tel: (303) 871-2205 | Fax: (303) 871-4242 | Email: info@hcc.du.edu

AUTHORIZATION FOR RELEASE OF INFORMATION

Student Name:______________________________________ DU ID #______________________________

Date of Birth:_________-_________-__________Contact Phone Number: (______)_________-_______________

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

Release/Request the following information: ☐ TO ☐ FROM ☐ Both TO and FROM

Name of Facility/Person:__________________________________

Phone number: ___________________________ Fax number: ______________________________

Address/City, State, Zip:____

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.

(MEDICAL RECORD)

☐ Medical Data/Information related to:

- ☐ Visit type/date: ____________________
- ☐ Laboratory Tests (dates)_______________________
- ☐ Gynecological, i.e. pap smears (dates)__________________
- ☐ Immunizations
- ☐ HIV/AIDS testing result
- ☐ Other (specify): ____________________

☐ Verbal Communication only

- ☐ Medical Services / Treatment
- ☐ Other (specify): ___________________

☐ The patient's entire medical (not including mental health) record generated in this office

(MENTAL HEALTH /COUNSELING/PSYCHIATRY RECORD)

☐ Verbal Communication (specify): ____

☐ Psychiatric/medication management treatment notes: (covering what dates-specify): __________________

☐ The client's mental health record generated in this office (indicate specifics in the box below)

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 (dates/number of visits)
- ☐ information pertaining to mental health treatment notes (session notes/documented contacts)
- ☐ information pertaining to treatment summary (closing summary—includes number of sessions, diagnosis, focus of treatment, treatment progress)
- ☐ information pertaining to psychological assessment

Purpose of Disclosure: *(check one or more)*

☐ Health Care / Continuity of Care ☐ Insurance / Billing ☐ School ☐ Legal

☐ Employment/Internship ☐ Other (specify): ___________________________

This authorization is valid for the academic year for the date 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 Health and Counseling Center cannot require you to sign this Authorization as a condition to the provision of services; however, your 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.

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Signature of Patient or Legal Representative *Date Signed*