Regis University Student Health Services
3333 Regis Boulevard, F-12
Denver, Colorado 80221-1099
303.458.3558
Fax: 303.964.5406

AUTHORIZATION TO RELEASE INFORMATION

_____ (Client Name) _____ (Date of Birth)
I, _____ authorize Regis University Student Health Services to obtain information from, and share information with the party listed below. I give the party below my permission to release all information relevant to my treatment. Any records to be released from Regis University Student Health Services must be originated from Regis University Student Health Services only.

_____
_____
_____

The information exchanged may include:

_____ immunization records
_____ psychological history
_____ discharge summary
_____ treatment plan(s)
_____ verbal & written progress
_____ treatment attendance/compliance
_____ drug/alcohol history & treatment
_____ all of the above information
_____ other:_____

_____ history & physical examination
_____ psychiatric history
_____ medication history
_____ physician/provider's order
_____ laboratory data/diagnostic tests
_____ history of legal involvement

The information may be used for:

_____ assessment
_____ continuity of care
_____ service planning
_____ mandated treatment attendance/compliance
_____ all of the above reasons
_____ other:_____

Provider shall not condition treatment upon client signing this authorization and client has the right to refuse to sign this form. The client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable Colorado law may protect such information. I understand that I may revoke this authorization to release/request information, except to the extent that the provider has taken action in reliance thereon, by giving written notice to Regis University Student Health Services. Without such revocation, this authorization shall expire on ___/___/_____ , or if left blank, six months following termination of treatment. I release Regis University Student Health Services from all liability for releasing such information.

_____ _____ _____
Client/Parent/Legal Guardian Signature Date Witness Signature

NOTICE TO WHOM THIS INFORMATION IS GIVEN: This information has been disclosed to you from records whose confidentiality is protected by Federal Law. Federal regulations prohibit you from making further disclosure of this information without the specific consent of the person to whom it pertains.

I hereby revoke this Authorization to Release/Request Information

_____ _____ _____
Client/Parent/Legal Guardian Signature Date Witness Signature

A copy or facsimile of this authorization is as valid as the original.