HEALTH SERVICES
ph (719)549.2830
fx (719)549.2646
csupueblo.edu/SHS
email: shs@csupueblo.edu

COUNSELING SERVICES
ph (719)549.2838
fx (719)549.2945
csupueblo.edu/counseling-center

CONSENT/AUTHORIZATION TO ACCESS OR RELEASE PROTECTED HEALTH INFORMATION

_____

Last Name (PLEASE PRINT) **First** **Middle** **AKA**

_____

Date of Birth **PID** **Phone Number**

PLEASE NOTE: For PHI requested from CSU-Pueblo Student Health & Counseling Services, Mental Health and/or Counseling Records may be summarized and Medical Records will be copied. All records from outside providers that have been accepted as a part of the permanent record set will be included in the release.

Initial next to appropriate record request:

_____I request that CSU-Pueblo Student Health & Counseling Services *release my records to the following person or facility listed*:

_____I request that the facility listed below *release my records to CSU-Pueblo Student Health & Counseling Services*

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax: _____

CHECK ALL BOXES THAT APPLY

☐ Limited to records regarding specific illness/injury/mental health (state condition or approximate dates).
☐ Medical Records
☐ Billing
☐ Counseling Records
☐ Psychiatric Records
☐ Other: _____

PROTECTED HEALTH INFORMATION IS BEING USED OR DISCLOSED FOR THE FOLLOWING PURPOSE(S):

CIRCLE ONE: ATTORNEY PERSONAL RECORDS INSURANCE CONTINUITY OF CARE/PROVIDER

☐ I understand there is a charge for records copied/summarized for personal, attorney or insurance purposes this excludes continuity of care record requests for all medical facilities. Based on Colorado State Statutes, the charge for copying is $14.oo for the first 10 pages; $0.50 per page for pages 11-40; and $0.33 for each additional page.

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1. I understand the information to be released may include information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, mental health or psychiatric treatment, drug and alcohol education and treatment records and/or, genetic testing records. I give my specific authorization to release all health care information relating to such diagnosis, testing or treatment.
2. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure health care treatment. CSU-Pueblo Student Health and Counseling Services will not condition my treatment, payment, or healthcare benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to be solely for the purpose of creating PHI for disclosure to a third party.
3. I understand that I may cancel this authorization in writing at anytime, except to the extent that action has already been taken to comply or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Without my express cancellation, this authorization will automatically expire upon satisfaction of the need for disclosure, not to exceed 180 days from my date of signature. **I understand this authorization will not apply to care provided after date of my signature.**
4. The Board of Governors of Colorado State University System, CSU-Pueblo, and CSU-Pueblo Student Health and Counseling Services will not be responsible for recipients disclosure of information released pursuant to this authorization.
5. I understand the potential for information that is disclosed pursuant to this authorization to be redisclosed by the recipient and no longer protected by Federal or State Law. If another party receives the information as the result of an error in processing my request, I waive any and all claims related to the error and release CSU-Pueblo Student Health and Counseling Services of any liability to such error.
6. A copy of facsimile may be utilized with the same effectiveness as an original.

I have read and acknowledge that I understand the terms and conditions of this request. I release both facilities from any liability complying with this request.

_____ _____

Signature of Patient/Client (or Personal Representative) Date

_____

Description of Personal Representative's Authority

To Recipient: This information has been disclosed to you from records whose confidentiality may be protected by Federal and State laws or regulations, which may prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such laws or regulations. A general authorization for release of medical or other information is not sufficient for this purpose.

A copy of this completed authorization has been given, or offered. _____

Colorado State University Pueblo