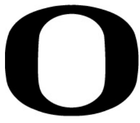

UNIVERSITY OF OREGON

Authorization to Release Medical Information

I Hereby Authorize: ______________________________
Facility/Practitioner Name

____
Street Address

____
City, State, Zip

____
Fax #

To Release Information to:
UNIVERSITY HEALTH CENTER
1232 UNIVERSITY OF OREGON
EUGENE OR 97403-1232
FAX # (541) 346-2747
ATTENTION: DR/NP ______________

For the Purpose of:

Specific Information to be Released:

****

By initialing, I specifically authorize the release of the following information:

☐ Mental Health Information
☐ HIV (AIDS) Antibody Test results & diagnosis/Treatment record
☐ Drug/Alcohol Information

I acknowledge that this data to be released may include information that is protected by federal law.

****

THIS CONSENT WILL BE VALID FOR 90 DAYS AND MAY BE REVOKED BY THE SIGNER AT ANY TIME EXCEPT WHEN ACTION HAS BEEN TAKEN.

______________________________ ______________________

____

Student Name Signature Date of Birth

____
Date

PLEASE RETURN A COPY OF THIS RELEASE WITH THE RECORDS