



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

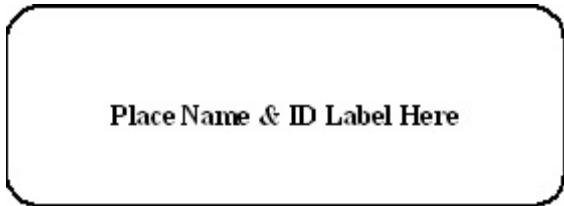
I acknowledge that this data to be released may include information that is protected by federal law.

 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

Clinic Forms: Record Release - to UHC: Revised 07/21/05: PLM/kmb - PDF for Web 09/05/2007 HT

UNIVERSITY HEALTH CENTER • Appointments & After Hours Nurse: 346-2770

Web: <http://healthcenter.uoregon.edu>

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