



Authorization for Release of Confidential Medical Information

Name _____ UO ID# _____ DOB _____

I hereby consent and authorize the University Health Center to:

- Initial Selection** Send a copy of my specific health information to person or entity named below
 Orally exchange specific health information with person or organization named below

Records released are limited to the last 2 years of information unless otherwise requested.

- | | | |
|---------------------------------|---|---|
| Initial | <input type="checkbox"/> Chart Notes | <input type="checkbox"/> Personal Health History |
| All Selections Requested | <input type="checkbox"/> Dental Records | <input type="checkbox"/> Dental X Rays |
| | <input type="checkbox"/> Allergy | <input type="checkbox"/> Immunization |
| | <input type="checkbox"/> Laboratory | <input type="checkbox"/> Physical Therapy /Sports Med |
| | <input type="checkbox"/> X-Ray Reports | |
| | <input type="checkbox"/> Other _____ | |

Protected records require specific authorization for release. You must initial each selection requested.

- | | |
|---|---|
| <input type="checkbox"/> Mental health information | <input type="checkbox"/> Genetic Testing |
| <input type="checkbox"/> HIV/ Aids testing & progress notes | <input type="checkbox"/> Drug / alcohol testing & treatment |

RELEASE TO: Name: _____
Address: _____
City/State/Zip: _____
Telephone/Fax: _____

- For the purpose of:**
- | | | |
|---|-------------------------------------|-------------------------------------|
| <input type="checkbox"/> Further medical care | <input type="checkbox"/> Graduation | <input type="checkbox"/> Relocation |
| <input type="checkbox"/> Insurance billing | <input type="checkbox"/> Other | |

DISCLAIMER: Your general medical record may contain information regarding mental health visits to primary care providers. Release of such information requires additional authorization from you. We make every effort to prevent release of this information; however, we cannot guarantee that every reference has been removed. We strongly recommend that your request indicate that your records be released directly to you for your inspection.

RE-RELEASE STATEMENT: I understand that once the information is released pursuant to this authorization it may be re-released by the recipient without knowledge or consent of the University Health Center or you. Re-release may not be protected by Federal or State privacy regulations.
You have the right to revoke this authorization at any time, except when the University Health Center has taken action in reliance on this authorization or the authorization was obtained as a condition of obtaining insurance. To revoke this authorization, please bring or mail a written signed statement to the University Health Center Medical Records department.

I have read this authorization and understand it.

Unless revoked this authorization will remain in effect for 360 days from the date it was signed.

Name: _____	Signature: _____
UO ID# _____	Date: _____
Phone # _____	e-mail address: _____
Date needed by: _____	circle choice: PICK UP MAIL
Records released to student by: _____	On: _____

Intake date: _____	Staff initials: _____
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