



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

Place Name & ID Label Here

Date

PLEASE RETURN A COPY OF THIS RELEASE WITH THE RECORDS