



UNIVERSITY OF OREGON

**Authorization for Release of and/or Verbal Exchange of Confidential Medical Information**

Name: \_\_\_\_\_  
UO ID: \_\_\_\_\_  
DOB: \_\_\_\_\_

**I hereby consent and authorize the University Health Center to:**

- Send a copy of my specific health information to person or entity named below
- Verbally exchange specific health information with person or organization named below

**Records released are limited to the last 2 years of information unless otherwise requested. You must INITIAL each.**

\_\_\_\_ Chart Notes      \_\_\_\_ Immunization      \_\_\_\_ Pharmacy      \_\_\_\_ X-Ray Image  
\_\_\_\_ Dental Records      \_\_\_\_ Laboratory      \_\_\_\_ Physical Therapy /Sports      \_\_\_\_ Other \_\_\_\_\_  
\_\_\_\_ Dental X Rays      \_\_\_\_ Personal Health History      \_\_\_\_ X-Ray Reports      \_\_\_\_\_

**Protected records require specific authorization for release. You MUST INITIAL each selection requested.**

\_\_\_\_ Drug/Alcohol Testing and Treatment      \_\_\_\_ HIV/AIDS Testing and Progress Notes  
\_\_\_\_ Genetic Testing      \_\_\_\_ Mental Health Information

**Release To: \_\_\_\_\_ AND/OR**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**Release to: (Please initial each requested)**

Student Services:

- \_\_\_\_ Academic Advising
- \_\_\_\_ Dean's Consult Committee  
*(Interdepartmental Student Assistance Group)*
- \_\_\_\_ Dean of Students Office
- \_\_\_\_ Disability Services
- \_\_\_\_ University Housing Office
- \_\_\_\_ University Counseling & Testing Center

**For the purpose of:**  Further medical care     Insurance billing     Student Assistance     Other: \_\_\_\_\_

**MENTAL HEALTH INFORMATION DISCLAIMER:** If you have not initialed release for Mental Health Information, we strongly recommend that your request indicate that your records be released directly to you for your inspection. We make every effort to prevent release of mental health information; however, mental health information is frequently incorporated into general medical information within the chart, therefore, we cannot guarantee that every reference has been removed.

**RE-RELEASE STATEMENT:** 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 by the patient. Re-release may not be protected by Federal or State privacy regulations. The patient has the right to revoke this authorization at any time, except after the University Health Center has taken action in reliance on this authorization, or if the authorization was obtained as a condition of obtaining insurance. To revoke this authorization, a written signed statement revoking authorization must be brought, mailed or faxed to the University Health Center Medical Records Department.

**Please allow 10 business days for the processing of your request for written records.**

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: \_\_\_\_\_

Date needed by: \_\_\_\_\_

UO ID#: \_\_\_\_\_

circle choice:    PICK UP            MAIL            FAX

Phone#: \_\_\_\_\_

Records released to student on: \_\_\_\_\_

E-mail address: \_\_\_\_\_

By: \_\_\_\_\_

Date: \_\_\_\_\_

Intake date: \_\_\_\_\_

Signature: \_\_\_\_\_

By: \_\_\_\_\_