UNIVERSITY OF OREGON

University Health Services
RELEASE OF CONFIDENTIAL INFORMATION

TO / FROM: (PLEASE CIRCLE)

UNIVERSITY OF OREGON HEALTH SERVICES
1232 UNIVERSITY OF OREGON
EUGENE, OREGON 97403
PHONE: (541) 346-2770
FAX: (844) 965-9250

TO / FROM: (PLEASE CIRCLE)

NAME______________________________
ADDRESS______________________________
CITY/STATE/ZIP ______________________________
PHONE: ______________________________
FAX: ______________________________
EMAIL: ______________________________

RECORDS RELEASED FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

______Continued Medical and/or Mental Health Care ______Student Assistance
______ Personal Use _____ Legal Purposes ____ Other (please list) ____________________

Records needed for appointment? YES NO Date: ____________________

RECORDS TO BE RELEASED:

____ Medical Chart Notes ____Immunizations ___ Mental Health Records (__ Counseling/ ___ Psychiatry)
____ Laboratory ____ PT Services ____ X-Ray Images ____ X-ray Report ___ Dental
____ Pharmacy ___ Letter of Support (AEC, Housing, etc.) ___ Other: ______________________________

****** SPECIAL AUTHORIZATION REQUIRED: You <u>MUST INITIAL</u> (if you want these records released) ******
____ Mental Health Records ____ Drug/Alcohol Testing and Treatment
____ Genetic Testing ____ HIV/AIDS Testing and Notes

<u>NOTE:</u> Only the most recent 2 years of records will be released, unless otherwise requested here.
____________ (50+ pages or multiple requests of records may result in an $18 processing fee)

METHOD OF RECORDS RELEASED: (more than one method chosen may result in additional fees, except verbal exchange)
Patient Portal ________** (Portal for *Current Students* only) Mail copy ______ Fax ______ Email _______
Verbal Exchange ______ (checking verbal does not constitute multiple methods) Pick-Up __________

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 Services 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 Services 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 Services Medical Records Department.

PLEASE ALLOW 10 BUSINESS DAYS FOR THE PROCESSING OF YOUR REQUEST

By signing below, I acknowledge that I am authorizing and consenting to the release of my medical records. Unless revoked in writing this authorization will remain in effect for 365 days from the date it was signed.

Name: ______________________________ UO ID: ______________ DOB: ____________
(Patient or Personal Representative)

Phone: ______________ Signature: ______________________________ Date: ________________