UNIVERSITY OF OREGON

University Health Center
Consent to Treat and Disclosure of Records

To be treated at the Health Center, we require your consent and acknowledgement of the terms below.

Acknowledgement and Consent:

1) I hereby consent to medical care and treatment as may be deemed necessary and advisable in the judgment of my physician or other provider, which may include but is not limited to: medical or surgical treatment or procedures; laboratory services; x-ray services; and/or other ancillary services rendered to me under the general or special instructions of my provider.

2) I acknowledge and understand that I am responsible for any and all charges for services and supplies rendered to me. I understand that it is my responsibility to check with my insurance company to determine coverage of any and all services received. Furthermore, if I have not provided consent for insurance billing, I understand that it is my responsibility to submit any relevant forms directly to my insurance company for possible reimbursement.

3) I agree to give advance notice if I need to cancel or reschedule an appointment and I understand that failure to do so may result in a No Show/Late Cancellation Fee which is not eligible for insurance reimbursement.

4) I assert that the information I provide regarding my medical condition is accurate and complete to the best of my knowledge.

5) I hereby consent to the University of Oregon, including any of its school officials, releasing my educational records, including health information, as stated below:

The University will only release records specifically related to and for the following purposes:

(a) responding to public health and safety emergencies;
(b) preventing or controlling disease, injury or disability;
(c) furthering my treatment and care;
(d) billing third parties for health care services or pharmaceutical drugs provided to me;
(e) paying for health care services or pharmaceutical drugs provided to me;
(f) managing my participation and coverage in a University health benefit plan; or
(g) complying with state, federal, and local health benefit reporting requirements.

Your records may be released to the following persons in the following circumstances:

(a) State, federal, and local public health authorities that are legally authorized to receive reports for the purpose of preventing or controlling public health emergencies, disease, injury or disability;
(b) State, federal, and local authorities that legally require the University to report health insurance benefit coverage;
(c) Persons, including University employees (for example, the University Registrar, Residence Life, and Dean of Students), classmates, close contacts, or, in rare circumstances, other members of the public, who are at risk of contracting or spreading a disease or condition, or who are in a position to prevent or lessen a serious and imminent threat to public health, to the extent necessary to protect the health or safety of me or other persons;

(d) Health care providers treating me and their staff;
(e) HIPAA covered entities and their staff participating in the electronic medical exchange network;
(f) Insurance companies that are obligated to pay for health care services and pharmaceutical drugs provided to me; and
(g) Third parties that provide, bill for, or process payment for health care services and pharmaceutical drugs provided to me or that assist the University with managing coverage in a University health benefit plan.

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By signing below, I acknowledge and consent to the terms as outlined above.

Full Name Print: _____ Date: _____

Signature: _____ UO ID #: _____

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