

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Name _____ ID # _____ DOB _____

I hereby Consent and Authorize Center for Student Health and Counseling to:

CHECK AT LEAST ONE Send a copy of my specific health information to person or organization named below
 Receive a copy of specific health information to person or organization named below
 Continual oral or written exchange of specific health information with person or organization named below

CONSISTING OF (check all that apply) Entire Medical Record Entire Mental Health Record Lab reports
 Most recent Annual and Pap Diagnostic imaging reports Pathology report
Other _____

To /From
Name _____
Address _____ Telephone _____
City/State/Zip _____ FAX _____

FOR THE PURPOSE OF: (describe purpose of disclosure) Continuing Care; Insurance Review; Legal Review
Other _____

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed if I place my **INITIALS** in the applicable space next to the type of information.

- HIV/AIDS information
- Mental health information
- Genetic testing information
- Drug/alcohol diagnosis, treatment, or referral information

This area must be initialed in order for it to be included in your request.

If and to the degree consent is required to release personally identifiable information in these records under the Family Educational Rights and Privacy Act, 20 USC 1232(g), (collectively referred to as FERPA) this signed document signifies such consent.

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage.
To revoke this authorization, please send a written statement to the SHAC Medical Records Coordinator at PSU, Center for Student Health and Counseling, PO Box 751, Portland, OR, 97207, and state that you are revoking this authorization.
You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information.

I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or specify _____. If I fail to specify an expiration date or event, this authorization will expire 360 days from the date on which it was signed.

Signature of individual or personal representative Date Your Telephone Number

If signed by someone other than the patient, include a description of personal representative's authority.

