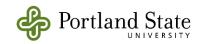


Patient Information & Consent

Center for Student Health & Counseling Portland State University Phone: 503.725.2800 Fax: 503.725.5812 1880 SW 6th Ave. Portland UCB Suite 200 PO Box 751 Portland, OR 97207



Release of Information Form

| Student Name: | PSU ID#: | Date of Birth: |
|---|---|--|
| | Center for Student Health and Counsel | |
| Release my records to (proceed to see Receive my records from (proceed to Maintain verbal and written community) | | v) |
| Recipient(s) of Records | | |
| B: Name of Individual or Organization: | | |
| | | Zip: |
| | | |
| Purpose of Information Release | | |
| C: Records are being released for the | purpose of: (check at least one) | |
| ☐ Continuing Care ☐ Personal Records | ☐ Insurance Review☐ Legal Review | Other: |
| Records to be Disclosed | | |
| D: The records that are to be disclosed | d are: (check all that apply) | |
| ☐ Entire Medical Record ☐ Lab Reports ☐ Most Recent Annual & Pap | ☐ Diagnostic Imaging Reports☐ Pathology Report | Entire Mental Health Record Psychiatric Records Other: |
| | nay apply. I understand and agree that | rmation listed below, additional laws relating to the this information will be disclosed if I place my |
| HIV/AIDS Information Mental Health Information | Genetic Testing Informat | ion Drug/Alcohol Diagnosis, Treatment or Referral Information |
| Authorization and Consent to Rele | ase Records | |
| used or disclosed for the purposes of reliance on the authorization or the To revoke this authorization, please Counseling, PO Box 751, Portland, PO Box 751, PO Box | described in this written authorization. The only authorization was obtained as a condition of one send a written statement to the SHAC Medical DR 97207, and state that you are revoking this aization. Refusal to sign the authorization will not circumstance when refusal to sign means your providing health information to someone else arm authorizing and consenting to the release | Records Coordinator at PSU's Center for Student Health and |
| Signature of Individual OR Power of Attorn | nev with Identification Date | Telephone Number |

Official SHAC USE Date Received ____/___/____ Received By: Date Mailed/Given/Faxed _____/___(circle one) Comments/Reviewed For: Reviewer's Signature: OK to File (Date and Initial):

Requesting Provider Name: _____ (check one) Health Services: _____ Counseling Services: _____