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

Fax Records to 503-725-5812

Patient Information & Consent

Student Name: _____ PSU ID#: _____ Date of Birth: _____(mm/dd/yyyy)

A: I hereby consent and authorize the Center for Student Health and Counseling to:

☐ RELEASE my records (proceed to section below)
☐ RECEIVE my records (proceed to section below)
☐ MAINTAIN verbal and written communication with (proceed to section below)

B: Name of Individual or Organization: _____

Address: _____ City/State/Zip: _____

Telephone: _____ Fax: _____

C: Records are being released for the purpose of: (check at least one)

☐ Continuing Care
☐ Personal Records
☐ Insurance Review
☐ Legal Review
☐ Other: _____

D: The records that are to be disclosed are: (check all that apply)

☐ Entire Medical Record – OR
☐ Specific Records: _____
☐ Entire Mental Health Record
☐ Letter of Support
☐ Assessment Report
☐ Psychiatric Records
☐ Other: _____

E: 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.**

_____ Mental Health Information
_____ Drug/Alcohol Diagnosis, Treatment or Referral Information
_____ HIV/AIDS Information
_____ Genetic Testing Information

Authorization and Consent to Release Records

- 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's 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.

F: 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.

_____ _____ _____

CLICK FOR INSTRUCTIONS
Must be hand-written or electronically drawn signature of individual *OR* Power of Attorney with Identification

Date (mm/dd/yyyy)

Telephone Number