AUTHORIZATION TO RELEASE MEDICAL/MENTAL HEALTH RECORDS

Southern Oregon University Health Center

Student Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ID No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE COMPLETE EACH SECTION LISTED BELOW**

***A***. **I hereby authorize Southern Oregon University Student Health & Wellness Center to**:

□ release information to

□ obtain information from

□ exchange information verbally with

***B***. **Name of organization or individual:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complete Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **The information will be used on my behalf for the following purpose(s**):

□ Continuing Care □ Personal Records □ Insurance Review □ Legal Review

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Limited to the following treatment for (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Limited to the following time period (be specific): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. By ***initialing*** the spaces below, I specifically authorize the release of the following medical records, *if such records exist:*

\_\_\_\_ Please send the **entire medical record** (this includes any or all of the items listed below).

\_\_\_\_ Medical records needed for continuity of care \_\_\_\_ Gynecologic exams, Pap smears and associated lab results

\_\_\_\_ Clinic office chart notes \_\_\_\_ Contraception records

\_\_\_\_ Emergency and Urgent care records \_\_\_\_ Physical therapy records

\_\_\_\_ Laboratory reports \_\_\_\_ All Hospital records

\_\_\_\_ Diagnostic imaging reports \_\_\_\_ Pathology reports  \_\_\_\_ Most recent five year history

\_\_\_\_ Medication records \_\_\_\_ Billing Statements

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. 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** related records (*must be initialed to be included in other documents*)

\_\_\_\_ **Mental Health** information (*must be initialed to be included in other documents*)

\_\_\_\_ **Genetic** testing information (*must be initialed to be included in other documents*)

\_\_\_\_ **Drug/Alcohol** diagnosis, treatment or referral information (*Federal Regulations, 42CRF Part 2, requires a description of how much and what kind of information is to be disclosed).* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(be specific)

***Please send records to:***

**SOU - Student Health & Wellness Center** Attn: ­­­­­­­­­­­­­­­­­­­­ \_\_\_\_\_\_\_

1250 Siskiyou Blvd., Ashland, OR 97520

or Fax: 541-552-6693: These records **may / may not** be sent by fax.

This authorization may be revoked at any time. Unless revoked earlier, this consent will expire 365 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request. Nominal fees may be assessed for requests for records. Please allow 10 business days for the processing of your request.

Date Signature of patient or person authorized by law

Date Signature of clinician approving release of records