EASTERN OREGON UNIVERSITY

Student Health & Counseling Center
One University Blvd.
La Grande, Oregon 97850
(541) 962-3524 Fax: (541) 962-3825

MEDICAL RECORDS RELEASE AUTHORIZATION

Patient Name:

Patient Phone #:

Date of Birth: /

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

I authorize: STUDENT HEALTH CENTER, EASTERN OREGON UNIVERSITY

To use and disclose a copy of the specific health information described below regarding:

_____
(Name of Individual)

Consisting of: CHART NOTES, E.R. NOTES, LABORATORY and/or PATHOLOGY REPORTS, MOST RECENT PHYSICAL, X-RAYS, MEDICATION LIST or OTHER:_____

_____
(Circle choices or describe information to be used/disclosed)

TO: _____

_____

_____

For the purpose of: AT THE REQUEST OF INDIVIDUAL AND CONTINUITY CARE.
(Describe each purpose of disclosure)

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 only 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

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 will mean you will not receive health services is if the health services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure. Your refusal to sign this authorization does not adversely affect your enrollment in a health plan or eligibility for health benefits, unless the authorized information is necessary to determine if you are eligible to enroll in the health plan.

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. Any uses or disclosures already made with your permission cannot be undone.

To revoke this authorization, please send a written statement and state that you are revoking this authorization.

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

I have read this authorization and I understand it.

Unless revoked, this authorization expires _____(insert applicable date or event).

By:_____ Date:_____
(Signature of individual or personal representative)
Description of personal representative's authority:_____