**RELEASE OF INFORMATION**

Authorization for the Exchange of Medical Information.

________**RELEASE RECORDS <u>TO</u> UHC** OR _______ **REQUEST RECORDS <u>FROM</u> UHC**

| **UNIVERSITY HEALTH CENTER**<br>1232 UNIVERSITY OF OREGON<br>EUGENE, OREGON 97403<br>PHONE: (541) 346-2770<br>FAX: (541) 346-2747<br>uhcmedicalrecords@uoregon.edu | **NAME**________________________________________<br>**ADDRESS**______________________________________<br>**CITY/STATE/ZIP** _________________________________<br>**PHONE:**____________________ **FAX:**________________<br>**ATTENTION:**___________________________________ |
|---|---|

**PURPOSE OF RELEASE:**

_______Continued medical care
_______ Insurance purposes
_______Student assistance
_______ Other (please list) ____________________________

Records needed for an appointment? YES NO Date :_________________________

**RECORDS TO BE RELEASED:**

_____ Medical Chart Notes _____ Immunizations _____ X-Ray Reports _____ Dental Records
_____ Dental Images _____ Laboratory _____ PT /Sports Medicine _____ X-Ray Image

****SPECIAL AUTHORIZATION REQUIRED: You <u>MUST</u> initial (if you want these records released)****

_____ HIV/AIDS Testing and Progress Notes _____ Mental Health Records
_____ Alcohol & Chemical Dependency Treatment _____ Genetic Testing

**METHOD OF RECORDS RELEASED:** (more than one method chosen may result in additional fees, except verbal exchange)

**Mail copy** _______ **Verbal exchange** _______ **Pick up** _______ **Fax** _______ **Patient Portal** _______ **

(**Portal is for *Current Students only* when records are released to the Student)

**RE-RELEASE STATEMENT:** Once the information is released pursuant to this authorization, it may be re-released by the recipient without knowledge or consent of the University Health Center or by the patient. Re-release may not be protected by Federal or State privacy regulations. The patient has the right to revoke this authorization at any time, except after the University Health Center has taken action in reliance on this authorization, or if the authorization was obtained as a condition of obtaining insurance. To revoke this authorization, a written signed statement revoking authorization must be brought, mailed or faxed to the University Health Center Medical Records Department.

**PLEASE ALLOW 10 BUSINESS DAYS FOR THE PROCESSING OF YOUR REQUEST**

(Nominal fees may be assessed for repeat requests for the same record set or records exceeding 50 pgs.)

**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.**

Print Name:_________________________________ UO ID:__________________ DOB:__________________

Signature:__________________________________ Date: __________________ PHONE:___________________