UNIVERSITY OF OREGON

University Health Services
RELEASE OF INFORMATION

WHAT WOULD YOU LIKE TO DO:

_____ UHS SHARE MY RECORDS WITH

_____ UHS GET MY RECORDS FROM

_____ I WOULD LIKE A COPY FOR MYSELF

NAME_____
ADDRESS_____
CITY/STATE/ZIP _____
PHONE: _____
FAX: _____
EMAIL: _____

RECORDS RELEASED FOR THE PURPOSE OF:

_____Continued Medical and/or Mental Health Care _____Student Assistance
_____ Personal Use _____ Legal Purposes ____ Other (please list) _____

Records needed for appointment? YES NO Date: _____

RECORDS TO BE RELEASED:

____ Medical Chart Notes ___Immunizations ____ Mental Health Records (__ Counseling/ ___ Psychiatry)
____ Laboratory ____ PT Services ____ X-Ray Images ____ X-ray Report ___ Dental
____ Pharmacy ___ Letter of Support (AEC, Housing, etc.) ___ Other: _____

****** SPECIAL AUTHORIZATION REQUIRED: You <u>MUST INITIAL</u> (if you want these records released) ******
____ Mental Health Records ____ Drug/Alcohol Testing and Treatment
____ Genetic Testing ____ HIV/AIDS Testing and Notes

<u>NOTE:</u> Only the most recent 2 years of records will be released, unless otherwise requested here.
_____ (50+ pages or multiple requests of records may result in a $18 processing fee)

METHOD OF RECORDS RELEASED: (more than one method chosen may result in additional fees, except verbal exchange)
Patient Portal _____** (Portal for *Current Students* only) Mail copy _____ Fax _____ Email _____
Verbal Exchange Only _____ (checking verbal does not constitute multiple methods) Pick-Up _____

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 Services 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 Services 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 Services Medical Records Department.

PLEASE ALLOW 10 BUSINESS DAYS FOR THE PROCESSING OF YOUR REQUEST

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: _____
(Patient or Personal Representative)

Signature: _____Date:_____ Phone: _____

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