

**University Health Services
RELEASE OF INFORMATION**

WHAT WOULD YOU LIKE TO DO:

☐ UHS SHARE MY RECORDS WITH

NAME

☐ UHS GET MY RECORDS FROM

ADDRESS

☐ I WOULD LIKE A COPY FOR MYSELF

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 ☐ Immunizations ☐ *Counseling ☐ *Psychiatry ☐ *Behavioral Health Consultant

☐ Laboratory ☐ Physical Therapy ☐ X-Ray Images/Report ☐ Dental

☐ Pharmacy ☐ Letter of Support (AEC, Housing, etc.) ☐ Other:

****** SPECIAL AUTHORIZATION REQUIRED: You MUST INITIAL (if you want these records released) ******

☐ Mental Health Records (*Counseling, Psychiatry & BH Consultant) ☐ Genetic Testing

☐ Drug/Alcohol Testing and Treatment ☐ HIV/AIDS Testing and Notes

NOTE: 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: (Methods checked below include verbal communication)

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:
(Patient or Personal Representative)

UO ID: DOB:

Signature: Date: Phone:

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