



## RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

TO / FROM: (PLEASE CIRCLE)

TO / FROM: (PLEASE CIRCLE)

UNIVERSITY OF OREGON HEALTH CENTER  
1232 UNIVERSITY OF OREGON  
EUGENE, OREGON 97403  
PHONE: (541) 346-2770  
FAX: (541) 346-2747

NAME \_\_\_\_\_  
ADDRESS \_\_\_\_\_  
CITY/STATE/ZIP \_\_\_\_\_  
PHONE: \_\_\_\_\_  
FAX: \_\_\_\_\_  
EMAIL: \_\_\_\_\_

### RECORDS RELEASED FOR THE PURPOSE OF: (INITIAL ALL THAT APPLY)

\_\_\_\_ Continued Medical Care    \_\_\_\_ Student Assistance    \_\_\_\_ Other (please list) \_\_\_\_\_

Records needed for appointment? YES NO Date: \_\_\_\_\_

### RECORDS TO BE RELEASED:

\_\_\_\_ Chart Notes    \_\_\_\_ Immunizations    \_\_\_\_ Pharmacy    \_\_\_\_ X-Ray Reports  
\_\_\_\_ Dental Records    \_\_\_\_ Laboratory    \_\_\_\_ PT /Sports Medicine    \_\_\_\_ X-Ray Image

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

\_\_\_\_ Drug/Alcohol Testing and Treatment    \_\_\_\_ HIV/AIDS Testing and Progress Notes  
\_\_\_\_ Genetic Testing    \_\_\_\_ Mental Health Information

**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 an \$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 \_\_\_\_\_ (checking verbal does not constitute multiple methods)

**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

**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.**

Name: \_\_\_\_\_ UO ID: \_\_\_\_\_ DOB: \_\_\_\_\_  
(Patient or Personal Representative)

Phone: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

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