UNIVERSITY OF OREGON

# Parent/Guardian Form

## UO Student Health Benefits Plan Enrollment Form
## Domestic Minor Student

The UO Student Health Benefits Plan is comprehensive health insurance, offered in partnership with PacificSource, which provides coverage for services on campus as well as locally and nationally. For specific plan information, terms and conditions, and costs refer to the University Health Center Website at healthcenter.uoregon.edu/insurance. The cost of insurance will be billed to the student's University of Oregon account on a term by term basis. Failure to meet payment deadlines will result in a $100 late fee and an academic hold on the student's account.

Student's Name:___________________________ Date of Birth:_____________ UO ID:____________________

Student's Social Security Number: ________________________________ (Required for Federal Tax Reporting Purposes)

I have read, understand, and agree to all of the terms and conditions of enrollment as outlined in the Student Guide and wish to enroll my dependent in the plan. Note: All students will be confirmed as eligible (per the rules outlined in the Student Guide) prior to enrollment and through the Compliance Deadline. Any student found to be ineligible will be declined enrollment and notified accordingly.

I hereby consent to the UO, including any of its school officials, releasing my child's educational records as stated below:

Purpose and specific records to be released:

A) Responding to public health and safety emergencies;
B) Preventing or controlling disease, injury or disability;
C) Furthering my child's treatment and care;
D) Billing third parties for health care services or pharmaceutical drugs provided to my child; and to pay for health care services or pharmaceutical drugs provided to my child;
E) To comply with federal laws and regulations.

Records may be released to:

A) Public health authorities that are legally authorized to receive reports for the purpose of preventing or controlling public health emergencies, disease, injury or disability;
B) Persons who are at risk of contracting or spreading a disease or condition if other law authorizes the University to notify such individuals as necessary to carry out public health interventions or investigations;
C) Health care providers treating me and their staff;
D) HIPAA covered entities and their staff participating in the electronic medical exchange network;
E) Insurance companies that are obligated to pay for health care services and pharmaceutical drugs provided to me; and
F) Other third parties that process payment for health care services and pharmaceutical drugs provided to me.
G) Federal agencies, including but not limited to, the internal revenue service.

I understand that unless I revoke this consent in writing and deliver it to the UHC, it shall remain in effect and my child's educational records will be disclosed as set forth above.

Parent/Guardian Name (Printed): ____________________________________

Parent/Guardian Signature: _________________________________________ Date:_____________________________

**UNIVERSITY HEALTH CENTER · Student Health Insurance: (541) 346-3232**
**Web: http: // healthcenter.uoregon.edu**
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