UNIVERSITY OF OREGON

RELEASE OF CONFIDENTIAL MEDICAL INFORMATION

TO / FROM: (PLEASE CIRCLE)

UNIVERSITY OF OREGON HEALTH SERVICES
1232 UNIVERSITY OF OREGON
EUGENE, OREGON 97403
PHONE: (541) 346-2770
FAX: (844) 965-9250

TO / FROM: (PLEASE CIRCLE)

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) 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.

Name: _____ UO ID: _____ DOB: _____
(Patient or Personal Representative)

Phone: _____ Signature: _____ Date: _____

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