Medical Records and Referrals, Room 115 Tel 541-737-7571 | **Fax 541-737-9665**
Student Health Services, Oregon State University
201 Plageman Building, Corvallis, OR 97331 | Email: SHSreferrals@oregonstate.edu

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

1. PATIENT NAME: (Please use black ink) **OSU ID#:** **DATE OF BIRTH**:

2. I HEREBY CONSENT AND AUTHORIZE: (Doctor Or Facility Who Has The Records Now**)**

Doctor or Facility Name_____

Address_____Telephone_____

City/State/Zip_____FAX_____

3. TO RELEASE THE FOLLOWING INFORMATION:

____ Entire Medical Record **OR** (Please specify):

____ Immunizations ____ Diagnostic imaging reports ____ Lab reports ____Prescription Records

____ TB information, including X-ray report if applicable ____ Most recent Annual and Pap

____ Other _____

4. INITIALS

If the information to be disclosed contains any of the types of records or information listed below, additional laws relating to the use and disclosure of the information may apply. I understand and agree that this information will be disclosed **ONLY** if I place my **INITIALS** in the applicable space next to the type of information.

____HIV/AIDS information ____ Genetic testing information

____Drug/alcohol diagnosis, treatment, or referral information ____ Mental health information

5. TO WHOM DO YOU WISH TO RELEASE/EXCHANGE (Including Orally) **YOUR RECORDS WITH:**

Name_____

Address_____Telephone_____

City/State/Zip_____FAX_____

6. FOR THE PURPOSE OF: (check purpose of disclosure)

____ Continuing Care ____ College Entrance Requirements ____Internship ____Other

You may revoke this authorization in writing at any time. If you revoke your authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Medical Records at OSU Student Health Services, 201 Plageman, Corvallis, OR 97331 and state that you are revoking this authorization.

You do not need to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services. The only circumstance when refusal to sign means you will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else and the authorization is necessary to make that disclosure.
If and to the degree consent is required to release personally identifiable information in these records under the Family Education Rights and Privacy Act, 20 USC 1232(g), (collectively referred to as FERPA), this signed document signifies such consent.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV/AIDS information, mental health information, genetic testing information and drug/alcohol diagnosis, treatment or referral information. I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or until (whichever is sooner) _____.
If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

_____ _____ _____

Signature of individual or personal representative Today's Date Your Telephone Number