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

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

Patient Name	OSU ID#	Date of Birth

I hereby consent and authorize (Doctor or facility who has the records now):

Doctor/Facility Name					
Street Address					
City		State		Zip	
Phone		Fax			

To release the following information:

	Entire Medical Record **or only** (please specify):		
	Immunizations		Diagnostic imaging reports
	Lab reports		Prescription records
	TB information, including x-ray if applicable		Most recent annual exam and pap
	Other (describe)		

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

To whom do you wish to release/exchange your records with? This includes verbal exchange:

Doctor/Facility Name					
Street Address					
City		State		Zip	
Phone		Fax			

What is the purpose for which this information will be used? (Check the purpose of disclosure):

For the purpose of:			
	Continuing care		Internship
	College entrance requirements		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 disclosure and no longer be protected under federal law. However, I also understand that federal or state law may restrict disclosure 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 patient or personal representative	**Today's Date**	**Your Phone Number**