Student Health Services
850 SW 26th St; Corvallis, OR 97331
P: 541-737-7609 F: 541-737-9665
SHSRecords@Oregonstate.edu

Release of Information Form

Fax Records to 541-737-9665

Patient Information & Consent

Student Name:_____ OSU ID#:_____ Date of Birth: _____

A: I hereby consent and authorize the Oregon State University Student Health to (check all that apply):

- ☐ Release my records to
- ☐ Receive my records from
- ☐ Maintain verbal and written communication with

Recipient(s) of Release of Information Form

B: Name of Individual or Organization: _____

Address:_____ City/State/Zip:_____

Telephone:_____ Fax: _____ Email: _____

Purpose of Information Release

C: Records are being released for the purpose of (check at least one):

- ☐ Continuing Care
- ☐ Personal Records
- ☐ Insurance Review
- ☐ Legal Review
- ☐ Billing/Insurance
- ☐ Other: _____

Records to be Disclosed

D: The records that are to be disclosed are (check all that apply):

- ☐ Entire Medical Record
- ☐ Lab Reports
- ☐ Most Recent Annual & Pap
- ☐ Diagnostic Imaging Reports
- ☐ Weights/Vitals
- ☐ LTBI
- ☐ Entire Mental Health Record
- ☐ Billing/Insurance
- ☐ Other: _____

E: 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 if I place my INITIALS in the applicable space next to the type of information.**

_____ HIV/AIDS Information
_____ Genetic Testing Information
_____ Substance Use
_____ Mental Health Information

Authorization and Consent to Release Records

- 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 if a company has already acted based on the given permission, or if getting that permission was necessary to get insurance coverage.
- To revoke this authorization, please send secure message through the student health portal to Medical Records. Patients without access to the portal need to submit statement to the Medical Records Coordinator at SHSRecords@Oregonstate.edu, or mail to above address, and state that you are revoking this authorization. Upon review by MRC, signature or Photo Identification may be required.
- You are not required to sign this authorization. Refusal to sign the authorization will not adversely affect your ability to receive health care services or reimbursement for services.

F: 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.

_____ _____ _____

Must be hand-written or electronically signed by individual | **Date** | **Telephone Number**