Student Health Services
110A Plageman, 108 SW Memorial Place
Corvallis, OR 97331
P 541-737-7609 | F 541-737-9665
shsrecords@oregonstate.edu

Name: _____

ID: _____

DOB: _____

CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I hereby consent and authorize the exchange of medical information.

1. Patient Name	OSU ID#	Date of Birth

2. Release Records From (Doctor/Facility who has the records now):

Name:		
Address:		
City/State:		
Phone:	Fax:	Email:

3. Release Records to (whom do you wish to release/exchange records with?) This includes verbal exchange:

Name:		
Address:		
City/State:		
Phone:	Fax:	Email:

4. To release the following information (check all that apply):

	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):		

5. 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

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

	Continuing care		Internship
	College entrance requirements		Other

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. 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. 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. 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)_____ (place date here).

Signature of patient or personal representative	**Today's Date**	**Your Phone Number**