



Integrated Student Health Center

AUTHORIZATION FOR USE & DISCLOSURE OF INFORMATION

Please mail, e-mail, or fax completed form to: ISHC, 3201 Campus Drive, Klamath Falls, OR Phone: 541.885.1800 | Fax: 541.885.1866 | email: health@oit.edu

In order to comply with your release request, please fill out this form carefully and completely! Much of the information is REQUIRED by federal and state law. Patient/representative may be charged a fee to complete the release of medical information authorization below.

Patient Name: \_\_\_\_\_ Other Names Used: \_\_\_\_\_

Current Address: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Phone: \_\_\_\_\_ Student ID: 918- \_\_\_\_\_ Last four of SSN: \_\_\_\_\_

Purpose of Release Request:

- Continuity of Care, Legal Reasons, Externship Site, Personal Use, New Job, Other

Request Initiated by:

This request is being initiated at the request of the patient or at the request of the recipient

Type of General Medical Information to be Released:

- Entire Medical Record, Physician note and records, Vaccine and Titer records, Contraception records, Lab test results, Imaging reports, Pathology reports, Medication records, Gynecologic history, exams, Pap smears, Other records or test results

I authorize the information designated above to be released from:

Name of Facility: Integrated Student Health Center Address: 3201 Campus Drive City/State/Zip: Klamath Falls, Oregon 97601 Phone: 541.885.1800 Fax: 541.885.1866

I authorize the information designated above to be released to:

Note: Do not indicate "Self" - a specific name is required by law.

Name of Facility/Person: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Information is to be: Mailed, FAXed (Check One - E-mail is not considered a secure method of transmission)

Expiration of Authorization of Release

This authorization is valid for one year from the date of authorization unless revoked by the patient orally or within writing at an earlier time. I understand that if I am requesting information from the ISHC I can revoke this authorization at any time by calling 541-885-1800. The exception is when the action has already occurred as instructed in this authorization. If signing for a person over 18 years of age, proof of guardianship, power of attorney, or executor of estate must be provided.

Disclosure & Authorization Signature (Required)

I understand that I do not have to sign this authorization. My refusal to sign this authorization will not affect my ability to receive health care services or reimbursement for services except in the circumstance that 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. I understand that once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient without the knowledge or consent of the ISHC or myself. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS information, mental health information, drug/alcohol conditions or genetic information.

Protected Records section containing authorization text, list of protected records (Mental Health, Drug/Alcohol, HIV/AIDS, Genetic), and signature line.

Signature of patient (or legally responsible person)

Relationship to patient

Date