Western Oregon University Student Health and Counseling Center
345 N. Monmouth Ave, Monmouth, Oregon 97361
Telephone: (503) 838-8313 Fax: (503) 838-8801

CS___ EY___
TB ___JK___
MG___ JS___
RG ___ SP___
BS ___ CO___
MM ___

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

Patient Name: _______________________________ Student ID:____________ Date of Birth: _____________

I hereby authorize the reciprocal release of medical information which pertains to my medical history, mental or physical condition, or treatment including information relating to my mental health diagnosis or treatment and/or substance abuse diagnosis and treatment as specified below.

Information Released From: ______________________________

Information Released To: ______________________________

Recipient Address: ______________________________

Recipient Phone/Fax: ______________________________

The Information to be disclosed is needed for Continuity of Care. HIV/AIDS, Mental Health and Alcohol/and or Drug abuse records must carry an additional signature to be released. **The information to be released:**

___ Most recent five years medical history records including lab, pathology and diagnostic imaging reports
___ Copy of recent Pap smear results and annual exam notes ___ Transcribed hospital records
___ Emergency and urgency care records
___ * Mental health information (please specify below) ***Signature**: ______________________

___ Intake/Discharge Summaries ___Medical Histories ___Police/Diversion Reports

___Education Histories ___Mental Health Evaluations ___Progress Notes

___Developmental Histories ___Social Histories ___Treatment Summaries

___ *HIV/AIDS related records *__Signature__: ______________________

___ * Drug/alcohol diagnosis, treatment or referral information ***Signature:** ______________________

___ Other ______________________________

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 and specifically require my authorization prior to redisclosure.

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 represent research related treatment and the authorization is necessary to participate in the research study and receive research related treatment.

You may revoke this authorization 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. Any use or disclosure already made with your permission cannot be undone.

This authorization will expire (check only one):
__ When I revoke this authorization (must be done in writing)
__ Upon the following date, event or condition ______________________
__ 180 days from the date of the signing

_____________________ ______________________________
Date Signature of patient

_____________________ ______________________________
Date Signature of personal representative

__ **I do** ___ **I do not** consent to the transmission of medical records via fax with the understanding that confidentiality at the receiving end cannot be guaranteed.