Oregon TECH
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 ☐ at the request of the recipient

Type of General Medical Information to be Released:

☐ Entire Medical Record (limited to 5 years of information and excludes other protected records)
☐ Physician note and records (limited to 2 years of information and excludes other protected records)
☐ Vaccine and Titer records
☐ Contraception records
☐ Lab test results
☐ Imaging reports (Xray, MRI, etc)
☐ Pathology reports
☐ Medication records
☐ Gynecologic history, exams, Pap smears and associated lab results
☐ Other records or test results (specify information/dates_____)

I authorize the information designated above to be released from:

Name of Facility/Person:_____

Address:_____

City/State/Zip:_____

Phone:_____ Fax:_____

I authorize the information designated above to be released to:

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

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

Protected Records

By initializing in the spaces below, I specifically authorize the disclosure of the following information that may have additional state and federal protections:

_____Mental Health Information
_____Drug/Alcohol Conditions
_____HIV/AIDS Information
_____Genetic Information

Authorized by:
*(signature required)*_____

_____Initial here to authorize *verbal* release between ISHC and the facility/person designated to the left.

(optional) Release of the above information is limited to:
_____Time period:_____
_____Treatment dates:_____

Expiration of Authorization of Release (Required)

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.

Signature of patient (or legally responsible person) Relationship to patient Date