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

Consent/Authorization To Disclose Medical Records Instructions

This form must be completed in its entirety:

1. Fill in all of your information in the #2 area.
2. Check either **"To"** (if sending information to OSU), **"From"** (if sending information from OSU) or **"Both"** (Exchanging information between OSU and the designated place).
3. In the first box put where the information will be coming from.
4. In the **"Records Released for the Purpose of:"** select the reason for releasing the medical record information.
5. In the **"Records to be Released"** - you must choose or state what records are needing to be released or requested.
6. In the **"Special Authorization Required: You Must Initial"** section. If you do not place an initial in those specific areas, none of that information will be sent.
7. In the **"Method of Release of Records"** you must choose which ways you would like your information to be sent. Most receiving facilities request the information to be faxed.
8. *Read through the rest of the information carefully.* Then **Print your name, sign the form**, put your **phone number** in, and **date the form**. If this form is *not signed (electronically or physically)* no information will be provided.
9. **Valid photo ID** for verification purposes *is required if form is not uploaded to the Student Patient Portal.*
10. Once the form has been completed it will ***expire in one year*** unless specified or revoked (in writing) by the patient.
11. Once completed please send to the Medical Records Office. If uploaded to the Patient Portal please send a message to Medical Records letting them know that it has been completed.

Important Information

The **authorization form** is meant to release or request medical record information that has already occurred. It is required to be completed before any information is released.

If you would like to *share past medical information* with your **parents** a new authorization form will need to be completed, and specify what information is needing to be released every time.

In regards to emergency situations please fill out an **Advance Medical Directive**, that would allow the designated person(s) to make medical decisions on your behalf if you are unable to.

Please add an **Emergency Contact** through the Patient Portal, in the event Student Health Services needs to contact them for emergency situations determined by clinician.

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

Consent/Authorization to Disclose Medical Information

1. **I hereby consent and authorize the exchange of medical information between the designated parties indicated below.**
2. **Name:** _____ **Date of Birth:**_____ **OSU ID#** _____

☐ Self ☐ Parents or ☐ Faculty/ School/ Employer
Name: _____
Address: _____
City/State/Zip/Country:_____
Phone: _____ Fax: _____
Email:_____

To OSU ☐ ⇒
From OSU ⇐ ☐
Exchange between both ☐ ⇔

Student Health Services
Medical Records
805 SW 26th St Corvallis, OR 97331
shsrecords@oregonstate.edu
F: 541 737 9665

RECORDS RELEASED FOR THE PURPOSE OF: (Check all that apply)

☐ Continuing Care ☐ Internship ☐ College Entrance ☐ Other(Describe):_____

If records are needed for an appointment: Date of Appointment: _____

RECORDS TO BE RELEASED: (If you need more than 2 years of records, please explain here). _____

_____

☐ Entire Medical Record (Most recent two years of records) ☐ Immunizations ☐ Lap Reports ☐ Prescription Records
☐ Diagnostic Imaging Reports ☐ TB Information (including X-ray if applicable) ☐ Most annual exam & pap
☐ Weights/Vital Signs ☐ Billing Information ☐ LTBI Information ☐ Substance use/ Mental Health Records
☐ Other: (Describe) _____

SPECIAL AUTHORIZATION REQUIRED: You **MUST INITIAL** if you want these records released. _____ HIV/AIDS Information _____ Genetic Testing Information _____ Mental Health Information _____ Substance Use

METHOD OF RELEASE OF RECORDS: (Check all that apply) If going to another facility, fax or email is the primary route.

☐ Encrypted Email ☐ Fax ☐ Printed/ In person ☐ Mail ☐ Verbal

RE-RELEASE STATEMENT: Once the information is released pursuant to this authorization, it may be re-released by the recipient without knowledge or consent of Student Health Services or by the patient. Re-release may not be protected by Federal or State privacy regulations. The patient has the right to evoke this authorization at any time, except after Student Health Services has acted in reliance on this authorization, or if the authorization was obtained as a condition of obtaining insurance. To revoke this authorization must be brought, mailed or faxed to Student Health Services Medical Records Department.

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. I understand that SHS may only disclose my past medical information, and that this form does NOT authorize disclosure of any information related to future care I may receive (exception: continuing clinical care). If you would like this to expire sooner than a year please place date here **(not todays date)** _____.

Name: _____ Signature:_____

Phone:_____ Date:_____