



**CONSENT/AUTHORIZATION TO DISCLOSE MEDICAL RECORDS**

**1. PATIENT NAME: (Please print)** \_\_\_\_\_  
 (Last, First, Middle Initial)

**DATE OF BIRTH:** \_\_\_\_\_ **PHONE#:** \_\_\_\_\_

**2. I HEREBY CONSENT AND AUTHORIZE:** (Provider Or Facility Who Has The Records Now)

Provider or Facility Name \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ FAX \_\_\_\_\_

**3. TO RELEASE THE FOLLOWING INFORMATION:**

Most recent Gyn exam note, Pap and STI lab reports       Lab reports  
 Immunization information       Diagnostic imaging reports  
 TB information, including X-ray report if applicable       Entire Medical Record  
 Other \_\_\_\_\_

**4. 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.

Mental health information       Genetic testing information  
 Drug/alcohol diagnosis, treatment, or referral information       HIV/AIDS information

**5. TO WHOM DO YOU WISH TO RELEASE/EXCHANGE (Including Orally) YOUR RECORDS WITH:**

Name \_\_\_\_\_  
 Address \_\_\_\_\_ Telephone \_\_\_\_\_  
 City/State/Zip \_\_\_\_\_ FAX \_\_\_\_\_

**6. FOR THE PURPOSE OF: (check purpose of disclosure)**

Continuing Care  Other \_\_\_\_\_

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. The only exception is when a covered entity has taken action in reliance on the authorization or the authorization was obtained as a condition of obtaining insurance coverage. To revoke this authorization, please send a written statement to Student Health Center, Medical Records at Pacific University, 2043 College Way, Forest Grove, OR 97116 and state that you are revoking this authorization.

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. 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 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. I have read this authorization and I understand it. Unless revoked, this authorization will expire in one year or until (whichever is sooner) \_\_\_\_\_.

If I fail to specify an expiration date or event, this authorization will expire one year from the date on which it was signed.

Signature \_\_\_\_\_

Today's Date \_\_\_\_\_

For Office Use Only  
 Circle one: Mailed Faxed  
 By: \_\_\_\_\_  
 Date: \_\_\_\_\_  
 Circle one: Scan File