



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/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)

Expiration of Authorization of Release (Required)

This authorization is valid for one year from the date of authorization or until (specific day) ___/___/___ unless revoked by the patient orally or within writing at an earlier time.

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.

Protected Records section containing authorization for disclosure of mental health, drug/alcohol, HIV/AIDS, and genetic information, along with a signature line and optional release limitations.

Signature of patient (or legally responsible person)

Relationship to patient

Date