Lewis & Clark College
Health Service
615 S. Palatine Hill Rd. Portland, OR 97219
Phone: 503-768-7165 Fax: 503-768-7167

AUTHORIZATION TO USE & DISCLOSE MEDICAL RECORDS / HEALTH INFORMATION

1. Patient Name____

LC ID#________________________ Phone____________________________ Date of Birth______________________

2. I HEREBY AUTHORIZE:

Doctor or Facility Name____

Address____Telephone____________________________

City/State/Zip____FAX______________________________

3. TO DISCLOSE (including orally) YOUR RECORDS / INFORMATION TO:

Lewis & Clark College – Health Service
615 S. Palatine Hill Rd.
Portland, OR 97219
Phone: 503-768-7165 FAX: 503-768-7167

4. THE FOLLOWING RECORDS / INFORMATION WILL BE DISCLOSED:

______Entire Medical Record OR (please specify):______________________________________

______Most Recent GYN Records (including pap, labs & treatments)

______Lab Reports ______Radiology Reports ______Prescription Record

______Other (please describe): ____

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 type of information will be disclosed ONLY if I place my initials in the applicable space next to the type of information.

______HIV / AIDS information ______Genetic testing information
______Drug/alcohol diagnosis, treatment, or referral information ______Mental health information

5. This information will be used for the following purposes:

______Continuation of care ______Other: ______________________________________

PATIENT INFORMATION

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.

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 Dr. John Hancock, Associate Dean of Students for Health and Wellness/Chief Psychologist (MSC 135) at Lewis & Clark College and state that you are revoking this authorization.

SIGNATURE

I have read this authorization and I understand it. Unless revoked, this authorization expires upon my graduation from Lewis & Clark, or on ________________________.

____ ______________________
Signature of Individual Today's Date