

AUTHORIZATION TO USE & DISCLOSE MEDICAL RECORDS / HEALTH INFORMATION

1. Patient Name _____

LC ID# _____ Phone _____ Date of Birth _____

2. I HEREBY AUTHORIZE:

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

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

Name _____

Address _____ Telephone _____

City/State/Zip _____ FAX _____

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